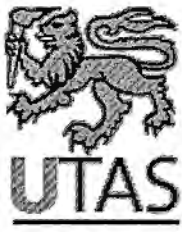


# Women General Practitioners in Australia

by Margaret Regal Kilmartin MBBS FRACGP

Submitted in fulfilment of the requirements

for the

Degree of Doctor of Philosophy

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Volume 1

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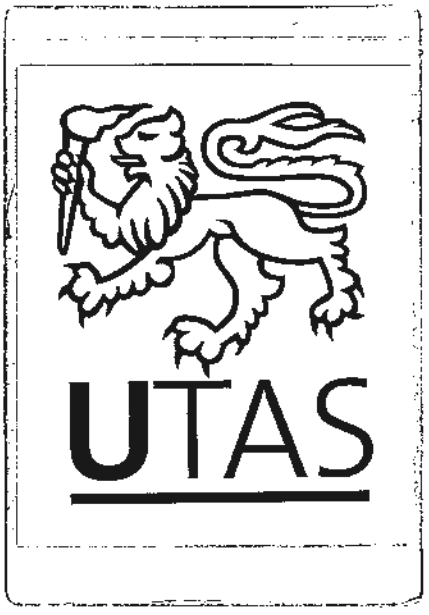


Signed: M. A. Kilvington

Dated 18. 12. 2006

# Women General Practitioners in Australia

## Thesis Abstract

This thesis addresses the key issues in the professional and non-professional lives of women general practitioners (WGPs) in Australia. It investigates their socio-political place within in the medical profession, organisations and Colleges particularly relating to General Practice and leads on to proposals that may ameliorate the dominant masculine culture that pervades the medical profession.

The investigation comprised a Delphi Study involving 40 WGPs and semi-structured interviews with 25 eminent General Practitioners (15 women, 10 men), both components including a breadth of geographical and work-backgrounds. The two studies were underpinned by relevant literature, history and sociological theory.

The Delphi Study highlighted the value of the whole-person concept and identified key issues that affect the professional and non-professional lives of WGPs. Developing satisfying relationships with partners and children and preserving their health and wellbeing were of primary importance to WGPs as wives, mothers and professionals. The women sought job satisfaction and most displayed distinctively non-masculine models of work. Male domination was evident in all aspects of the lives of the WGPs taking part in this study.

Interviews with the eminent GPs highlighted the existence of masculine power and patriarchy in the hierarchical structures of organisations of General Practice and in the General Practice environment. These interviews also provided insights to how the WGPs coped with the inequities they encountered.

It is concluded that we cannot examine the professional life of WGPs in isolation and problems of gender equity in the medical profession must be recognised as a first step towards their rectification. The thesis highlights the problems faced by WGPs in Australia and provides proposals for fostering a culture of inclusivity of both sexes in medical practice. There are indications that generational change will bring improvements to domestic problems and inappropriate work professional practices together with a culture inclusive of both male and female GPs.

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## Statement of Co-Authorship

The co-authored paper entitled "The balancing act: key issues in the lives of women general practitioners in Australia" presented in Appendix 3 recognises the contribution of others in its preparation. The various studies contained within this thesis were principally considered, planned, conducted and written by the candidate.

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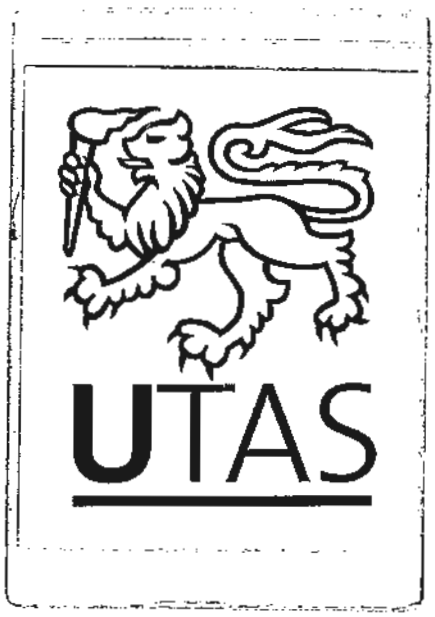

# Glossary of Acronyms

| | |
|---|---|
| AAGP | Academic Association of General Practice |
| AAAGP | Australian Association of Academic General Practice |
| AAMC | Association of American Medical Colleges |
| ABS | Australian Bureau of Statistics |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| ACRRM | Australian College of Rural and Remote Medicine |
| ADGP | Australian Divisions of General Practice |
| AFMW | Australian Federation of Medical Women |
| AGPAL | Australian General Practice Accreditation Limited |
| AIHW | Australian Institute of Health and Welfare |
| AMA | Australian Medical Association |
| AMC | Australian Medical Council |
| AMWAC | Australian Medical Workforce Advisory Committee |
| BCE | Before the Common Era |
| BEACH | Bettering the Evaluation and Care of Health |
| BMA | British Medical Association |
| BPP | Better Practice Program |
| CHF | Consumers Health Forum of Australia |
| CME | Continuing Medical Education |
| CPMC | Committee of Presidents of Medical Colleges |
| EEO | Executive Equal Opportunity |
| FACRRM | Fellowship of the Australian College of Rural and Remote Medicine |
| FMP | Family Medicine Program |
| FRACGP | Fellowship of the Royal Australian College of General Practitioners |
| FTE | Full-Time Equivalent |
| GPET | General Practice Education and Training |

| | |
|---|---|
| GPEA | General Practice Education Australia |
| GPPAC | General Practice Partnership Advisory Council |
| GP | General Practitioner |
| HIC | Health Insurance Commission |
| LRCP | Licentiate of the Royal College of Physicians |
| LSA | Licentiate of the Surgical Association |
| MBA | Masters of Business Association |
| MBBS | Bachelor of Medicine Bachelor of Surgery |
| MRCS | Member of the Royal College of Surgeons |
| MWIA | Medical Women's International Association |
| NHMRC | National Health and Medical Research Council |
| NRA | National Registrar Association |
| OMPs | Other Medical Practitioners |
| PIP | Practice Incentives Program |
| PD | Professional Development |
| PDP | Professional Development Program |
| PHCRED | Primary Health Care Research Evaluation and Development Program |
| QA | Quality Assurance |
| RACGP | Royal Australian College of General Practitioners |
| RANZCP | Royal Australian and New Zealand College of Psychiatrists |
| RDA | Rural Doctors Association |
| RDAA | Rural Doctors Association of Australia |
| RHTU | Rural Health Training Units |
| RMO | Resident Medical Officer |
| RRMA | Rural, Remote and Metropolitan Area (classifications) |
| RUSC | Rural Undergraduate Steering Committee |
| RWAs | Rural Workforce Agencies |
| SBO | State-Based Organisation (for the Divisions of General Practice) |
| SIPs | Service Incentives Payments |

| | |
|---|---|
| UDRH | University Departments of Rural Health |
| UNICEF | United Nations Children's Fund |
| VR | Vocational Registration |
| WGP(s) | Woman/Women General Practitioner(s) |
| WHO | World Health Organisation |
| WONCA | World Organisations of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians |
| WWPWPM | Wonca Working Party on Women and Family Medicine |

# Introduction

> "Then you should say what you mean" the March Hare went on..."At least I mean what I say - that's the same thing" [said Alice]..."You might just as well say" added the March Hare "that I like what I get is the same thing as I get what I like!" (Gardner 1970, p. 95).

## The Aims of The Research in This Thesis

The research conducted for this thesis aims to explore the key issues in the professional and non-professional lives of women general practitioners (WGPs)[1] in Australia, and to examine the socio-political space that these WGPs occupy in the medical profession and organisations and Colleges concerned with General Practice.

While the outcomes from this research may be beneficial to researchers considering issues of workforce, its focus is neither about workforce shortage, nor is it an analysis of the place of WGPs in the workforce and the implications of this in the context of history. Indeed workforce was not the focus of the Delphi study, or the semi-structured interviews conducted or the responses of the research participants.

There are numerous recent publications on medical workforce in Australia: (Australian Medical Workforce Advisory Committee 2005; Australian Medical

[1] The abbreviation WGP and WGPs are used in this thesis as abbreviations for woman general practitioners and women general practitioners respectively.

Workforce Advisory Committee 2005; Dowton 2005; Armstrong and Van Der Weyden 2006; Arnold 2006; Charles et al. 2006; Dahlenburg 2006; Del Mar and Dwyer 2006; Ellis et al. 2006; Fleming 2006; Fleming 2006; Harris and Harris 2006; Jackson 2006; Joyce and McNeil 2006; Joyce et al. 2006 (pp. 441-446) ; Joyce et al. 2006 (p. 182); Kidd et al. 2006; McRae 2006; Murray and Wronski 2006; Van Der Weyden 2006; Weller 2006). In contrast this research concerns the key issues for WGPs in Australia in the social context of their non-professional and professional lives, including the socio-political space they occupy in medical organisations and Colleges.

**Why was Research Needed on the Topic of Women General Practitioners (WGPs) in Australia?**

The proportion of medical practitioners who are female was shown in a national Australian study to have increased from 19.3% in 1991 to 35.2% in 2003 (Charles et al. 2004, p. 85). The sex ratio of students in Australian medical schools in 2001 was approximately 50:50, and by 2025 women are projected to comprise 42% of the medical workforce (Yelland and Yelland 2001, p. 53). In a 2003 report women comprised 60.5% of the doctors training to become general practitioners (GPs) (Medical Training Review Panel 2003, p. 9).

Despite the increasing proportion of females, there has been little research published in peer reviewed journals regarding the professional and non-professional lives of WGPs in Australia. In particular there is a lack of knowledge and understanding of

the factors that affect the work and lives of WGPs in Australia, how they manage their professional and non-professional lives, or how they deal with the numerous competing issues that confront them. Little is also known regarding the niche that WGPs fill in medical organisations and Colleges concerned with General Practice, how these organisations respond to their presence, or how they address these issues of concern.

Recent research projects relating to WGPs in Australia have been primarily concerned with WGPs in rural and remote locations (Tolhurst et al. 1997; Jorgensen 2000; Tolhurst et al. 2000; McEwin 2001; Tolhurst and Lippert 2001; Wainer 2001; Wainer et al. 2001; Roach 2002). However, a report in 2002 showed that only 28% of the doctors in rural and remote Australia were females and 65% of female rural GPs spend less than 5 years in rural locations (Doyle 2003, p. 9). Hence the gap in research relating to the professional and non-professional lives of WGPs from both urban and rural Australian locations needed to be addressed.

The voices and stories of the lifetime experiences of the WGP participants also provide a valuable insight into the composite mosaic of the lives of WGPs in today's society. In addition a detailed understanding of the issues raised by these WGPs would provide the community, governments and the profession a basis on which to frame recommendations and policies for the future.

**The Use of Critical Thinking and Critical Analysis in this Thesis**

Critical analysis and critical thinking are difficult to define. Essentially critical analysis/critical thinking entails more intellectual rigor, involving the application of rational and logical thinking when deconstructing texts that are read and written (Deakin University 2006, p. 1). Critical thinking has been defined by Scriven and Paul (2001) as:

> The intellectually disciplined process of actively and skilfully conceptualising, applying, analysing, synthesising and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning or communication, as guide to belief or action (Scriven and Paul 2006, p. 1).

The use of critical thinking and critical analysis of literature, sociological theory and data from the empirical studies in this thesis enables a richer understanding of the professional and non-professional lives of the WGP participants. This has particular value in understanding the medical culture at the time the research was undertaken, as well as contributing to the history and future of WGPs in Australia.

The author of this thesis draws upon the breadth of definition of critical analysis and critical thinking, the personal nature of the process, and the challenge of discovering the depth of knowledge relating to WGPs in Australia that will contribute to a better understanding of their place in General Practice. Scriven and Paul (2004) explain the

process of critical thinking as a personal and individual process of self-directed, self-disciplined, self-monitored and self-corrective thinking:

> It presupposes assent to rigorous standards of excellence...[and] it entails effective communication and problem solving abilities and commitment to overcome our native egocentrism and sociocentrism (Scriven and Paul 2006, p. 1).

**The Use of a Multi-strategy Approach in this Research**

Layder (1998) claims that a "multi-strategy approach to research increases the strength, density and validity of theoretical ideas and concepts that emerge from data collection and analysis" (Layder 1998, p. 68). Using as many different sources of data and/or methodological and analytical strategies as feasible and practical in tandem with each other enables the researcher to view the research from many angles and hence expand the use of the empirical data. There is also an opportunity for interchange and dialogue between methods, strategies, sources and techniques. Subsequently the research problem will have a greater potential yield of theoretical concepts and ideas. Individual data or collection techniques should "not be ruled out *a priori* because of some personal preference or prejudice..." (Layder 1998, p. 69).

Another advantage of multi-strategy research is that it contributes to triangulation which enables cross-checks on the validity of findings and concepts that emerge from data analysis. Relying on one source, strategy, or method, puts the researcher at risk of becoming focussed on one aspect at the expense of others. The iteration of a

number of approaches produces a synergy which enhances the research outcomes. As Layder says "a multi-strategy approach produces a multi-perspective 'overview' which increases the potential for more and more robust theoretical ideas" (Layder 1998, p. 68).

The research in this thesis uses a multi-strategy approach to investigate the professional and non-professional lives of WGPs in Australia. The components of the present investigation are:

- A Delphi study to elucidate the key issues in the professional and non-professional lives of WGPs.
- Semi-structured interviews to further investigate the issues raised in the Delphi study and the socio-political space that WGPs occupy in professional medical organisations.
- A historical backdrop that provides an Australian and international context to the lives of WGPs.
- An examination of the sociological theory that contributes to the formation of the theoretical framework for this research.

Using history as part of a multi-strategy approach serves as a validity check on the theoretical elements that emerge from examination of research on a contemporary topic. The aim of using history is not to make this thesis a historical contribution relating to medical women, but rather, as Layder says:

> A historical dimension is being employed as an *adjunct* to other

> forms of analyses and data collection. In this context a historical dimension is both a supplement and a complement to an analysis (Layder 1993, p. 175).

**The Application of History in this Thesis**

A historical perspective adds both empirical and analytic depth to a research problem. Consideration of the ways that aspects of social life have evolved, or how social conditions prevailed in earlier times is important, as the "past always impresses itself on the present in some way, even though this is not always apparent" (Layder 1998, p. 69). Investigating the past in order to assess how this may influence present circumstances involves reading history in a sociological way, and using historical material in order to draw out relevant sociological factors and coocepts.

According to Layder, elements of historical research are commonly used in short-term contemporary research on professions and this type of research does not require extensive use of primary sources. From a sociological point of view often only significant periods of social change or stability are important as they are intended to achieve a rich analysis. This adds depth to the research in a supplementary manner by contributing to theoretical ideas that are generated directly or indirectly through empirical research. Layder encourages researchers to utilise reliable historical data as a secondary source of material that can contribute to enrich their research (Layder 1993, pp. 172-179). The use of history as described by Layder forms a strong 'backbone' for the organisation and development of this thesis.

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**Chapter Outline**

Historical texts and journal articles are used in Chapters 1 and 2 to critically analyse the background and context of this thesis, and develop a case for this research. Chapter 1 introduces the sociological dimensions relating to international medical women and pioneering medical women in Australia. Chapter 2 reviews the demography of WGPs in Australia, the literature (1970-2004) relating to WGPs in Australia and the Australian General Practice environment (including medical organisations and Colleges) to elucidate a contextual background to the empirical research in this thesis.

Chapter 3 uses recent literature and journal articles (2005-2006) to confirm the current relevance of this research to the professional and non-professional lives of WGPs in Australia and the socio-political space they occupy in medical organisations and Colleges. Chapter 4 utilises current and historical literature to evaluate the sociological theory underpinning this thesis and the theoretical framework for this research. It also examines the application of social theory relating to this research on WGPs in Australia, and the status and careers of women in the medical profession and organisations.

Chapter 5 describes how the qualitative methodologies of the Delphi Technique and semi-structured interviews were used to investigate the key issues in the professional and non-professional lives of WGPs, the socio-political space they occupied in medical organisations and Colleges concerned with General Practice, and how these organisations addressed issues of concern for WGPs. The data for this research were

drawn from a national Delphi Study (October 1996 to January 1997) of 40 WGPs who articulated the key issues in their professional and non-professional lives, and from semi-structured, face-to-face interviews conducted in June to December 1998 with 25 GPs. The semi-structured interview participants (10 male and 15 female) all had experience in General Practice and had occupied senior positions in Australian medical organisations and Colleges concerned with General Practice issues.

Chapter 6 details the findings from the analysis of the Delphi Study and Chapter 7 presents and examines the findings from the analysis of the themes from the semi-structured interviews. In Chapter 8 the themes from the Delphi study and the semi-structured interviews (hereafter called the research) are combined to form the components of the final framework of this investigation (Appendix 1). These linked themes are critically evaluated in tandem with supporting evidence from literature, history, sociological theory, and the words of the research participants. Chapter 9 provides the conclusions of this thesis.

**The Meanings and Importance of the Research Findings**

Core elements of the professional and non-professional lives of WGPs were seen to form composite parts of a mosaic, and any attempt to separate these components fractures the whole-person concept. Support was also gathered for the argument that concerted attempts must be made to change the dominant masculine culture that exists in General Practice, medical organisations and Colleges. Encouraging a culture inclusive of both sexes will promote balance in the professional and non-

professional lives of all GPs.

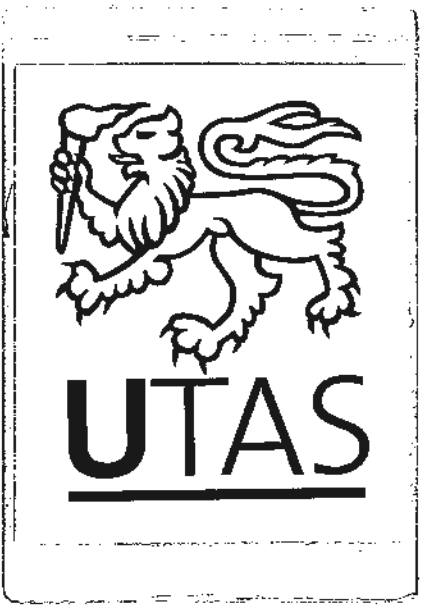
The themes arising from the research were examined in the light of relevant literature, history and theory, this supporting the contention that WGPs are subjected to masculine power in all aspects of their lives, but particularly in their professional workplace and medical organisations. The non-professional lives of the WGPs centred on their relationships with their partners, children and family. In addition WGPs were concerned about staying healthy and achieving balance in their roles as wives, mothers, GPs and professional women.

In their professional work WGPs sought job satisfaction as a high priority and most employed unique non-masculine models of work in General Practice. Their approach and style displayed in their work highlighted significant differences between male and female GPs.

The present generation of registrars in training for General Practice held significantly different values and priorities to those of previous generations, asserting that the provision of options was necessary for them to achieve satisfying professional and non-professional lives. The means of achieving these options were frequently very different from prior norms and cultures of older generations of GPs.

It was apparent from this research that the historical dominant masculine culture still exists, this affecting the role of WGPs in organisations concerned with General Practice. Hierarchical structures, the dominance of masculine knowledge and

subordination of feminine ways proved a challenge for WGPs who wanted to participate in organisations on terms that were acceptable to them. Patriarchy, bullying, gender discrimination and a club image need to be acknowledged and addressed if WGPs are to occupy positions of leadership in professional organisations and Colleges on an equal footing.



# Chapter One

## A Literature Review of The History of Medical Women

> Medicine is not a science. It is an art that uses science to explore what William Harvey called nature's closest secrets that we may better minister to her children (Miller 1994, p. 175).

## 1.0 Introduction

History is one element of the multi-strategy approach that is used in this thesis to explore the key issues in the professional and non-professional lives of WGPs in Australia, and the socio-political space that WGPs occupy in the medical profession and the organisations concerned with General Practice. This chapter provides a critical analysis of historical literature on international medical women and pioneering medical women in Australia and introduces sociological aspects relevant to the current situation of medical women in this country.

How WGPs in Australia manage to attend to their patients while deriving satisfaction in their professional and non-professional lives is little understood. By evaluating the history of the lives of international and national medical women as healers and pioneers a broader perspective of the lives of WGPs is achieved. Like Alice's conversation with the March Hare (cited in the introduction to this thesis), we can

better understand what WGPs mean in the stories they tell, and be assured that they mean what they say when they share their experiences.

# Section 1

## 1.1 Early History of Women Healers and Women In Men's Uniforms

### 1.1.1 Women as Healers

Women provided a key role in the care and healing of people during the classical periods of Egyptian, Greek and Roman civilizations and for the first 1 000 years of the Christian era (Ruben 1972, p. 215). They cared for common medical conditions and filled the role of obstetrician, gynaecologist, general physician, surgeon and bone-setter. They ministered to family, community, servants, slaves and livestock and used medicinal herbs and mystic practices to effect cures. The role of women healers was to cure diseases of mind and body as this has always been their natural function (Smith 1977, p. 1142). The knowledge that these women gained through their experience as healers was passed to other women through the generations.

Egyptian records confirm that women studied at the royal medical school at Heliopolis as early as 1 500 BCE, and on tombs and temples throughout Egypt illustrations are found of women performing surgery (Wynn 2000, p. 668). In ancient Greece, Hygeia and Panacea were goddesses of healing and were probably

independently practicing physicians (Wynn 2000, p. 668). Subsequent Greek women taught medicine and provided surgery, obstetrics and care of patients. Galen, the physician, reported the activities of medical women including Margereta, a prestigious army surgeon and Origenia, who used valuable remedies for hemoptysis aud diarrhoea. After the fall of Corinth the captive Greek medical women fetched a high price in the Roman slave markets as their skills were highly valued (Wynn 2000, p. 668).

In ancient Rome female physicians were called *medica,* a Latin word which means female doctor. They managed busy practices and were on equal footing with male physicians, but as the Roman Empire disintegrated medical science, art and literature declined. Healing fell to women at home and within holy orders, but as the medieval period progressed the education of women in medicine declined iu accord with the Church's promulgation of the inferiority of women (Wynn 2000, p. 668).

Trotula, one of the most distinguished women physicians of the 11th Century, lived in Salerno Italy, considered to be an outstanding medical teaching centre of the world. Her main interest was the alleviation of the suffering of women, and she authored many medical works, including one on obstetrics aud gynaecology that was used for more than 400 years. Both men and women studied under her tuition, in a period when influences from Arab, Jewish, Roman and Greek cultures united in intellectual achievements (Wynn 2000, p. 668). Trotula may have been the first female professor in a medical school. She was also engaged in clinical practice and wrote and taught on topics iu cosmetology, gynaecology, obstetrics and paediatrics until her death in

1097 (Ruben 1972, p. 252).

During the 13th Century European medicine commenced towards becoming a secular science and a profession. Women healers were precluded from universities and the passage of licensure laws plus the formation of guilds in England and France prohibited women from practicing medicine (Wynn 2000, p. 5). There was little science in the medieval medical training, the work of Plato, Aristotle, Galen and ancient Roman physicians remaining dominant authorities. Treatments were based on superstition, bleeding, leeches, incantations, quasi-religious practices and astrology. Surgery was considered a degrading menial task and dissection of bodies was unheard of (Ehrenreich and English 1973, p. 16-17).

As detailed in Chapter 4 of this thesis, for several centuries witches operated as the healers of sick people especially those who were poor. However by the 18th Century male physicians were the dominant providers of health care to the exclusion of women.

### 1.1.2 Women Healers Who Adopted the Uniform of Male Doctors

There are two notable cases of women adopting the guise of men in order to gain entry into reserved areas of medicine, those of Dr. Mary Walker (1832-1919), and (Inspector General) James Barry (1759-1865).

Mary Walker (a medical graduate of 1855) was a surgeon and feminist who aspired to

being granted a commission as an army surgeon in the American Civil War (1860-1865). Even though this commission was not granted, she joined the war effort to become an ambulance surgeon and eventually gained a paid contract and became the first female assistant surgeon. Walker usually wore tailored men's clothes of trousers topped by a tunic and a knee-length overskirt. She asserted her feminist convictions that women needed to be educated to enable them to be self-supporting, that there should be equal pay for equal work, and that if marriage fails then divorce should be the answer.

Mary was captured by the Confederates and was exchanged "man for man" to secure her release from prison. During her later life she was clearly identified as a woman and she was awarded the Congressional Medal of Honour in 1865. This medal was rescinded in 1917 on the grounds that there was insufficient reason indicated in available records to warrant her being granted the award (Smith 1977, p. 1151). Mary's case highlights the lack of recognition given to women for their significant contribution to medicine and the political use of rules and regulations to keep outstanding women in their proper place.

Inspector General James Barry was Britain's first woman doctor and is perhaps the most intriguing person in the history of the medical profession. James Barry qualified in medicine at the University of Edinburgh in 1812 and entered the British army in 1813. As an officer she served as a celebrated surgeon in various parts of the world over the next 40 years. She had the patronage of Lord Buchan who paved the way for her successful army career and her promotion was rapid (Hurwitz and

Richardson 1989, p. 301). The patronage of seniors has historically been important for the professional success of many men in medicine, an advantage enjoyed by few women including those who aspire to high office at the present time.

Barry used various disguises to conceal her sex, including large shoulder pads and an oversized sword and spurs, although her effeminate features raised suspicions. Her community work during her career was remarkable, examples being the implementation of clear and humane rules for treating lepers in the Cape Colony and conducting experiments into preventing corrosion in pipes carrying fresh water. In 1862 while in South Africa she was credited with performing the first caesarian section where both mother and baby survived.

Barry chose to operate professionally in medicine in a man's world and she rejected the traditional social and family roles expected of women at that time. She operated from within a professional structure using rank and power to make change and by accepting patronage she achieved medical advancement that was largely reserved for males. As the historian Lynne Friedli noted:

> Women who cross-dressed generally gained the higher social and economic status associated with being male. They had access to occupations that were limited to men notably in the military field. In addition dressed as men, they had greater mobility and employment prospects, with better pay (Hurwitz and Richardson 1989, p. 301).

History shows that women have made invaluable contributions to healing and caring for the sick. They have taken part in procedural medicine, surgery and midwifery and contributed to the academic progress of medicine. However, over the past few centuries they have been largely excluded from the more prestigious positions in this field. Hence, exploring the role and status of WGPs in Australia is of significance in this thesis.

# Section 2

## 1.2 The History of Women in Medicine and Science

### 1.2.1 Discrimination Experienced by Women in Medicine and Science

The historical accounts of discrimination or sexism that women in medicine and science have experienced provide important information for the investigation of the occurrence of these issues in the professional and non-professional lives of WGPs. Women have historically formed a minority in the scientific community and despite efforts to address this problem:

> Women remain dramatically absent from the membership of the informal communities and clubs that constitute the scientific establishment (Holloway 1993, p. 95).

Notable achievements by women in science and medicine during the 19th Century have been frequently set within recurriug themes of power, patriarchy and a dominant masculine culture. An example is the case of Ethyl Browne Harvey (1885-1965), a biologist and embryologist whose studies of induction preceded those of Noble Laureate Hans Spemann and Hilde Mangold by more than 10 years. Ethyl was an investigator at Princeton University for 25 years, yet she never became a professor (Holloway 1993, pp. 98-99).

Women in medicine and science sometimes operate in partnership with their husbands, a practice that continues to the present time. Irene Joliot-Curie and her husbaud Frederic Joliot-Curie operated as partners to win the 1935 Nobel Prize for their synthesis of new radioactive elements. More usually the dual partnership of medical professionals has favoured the career of the male partner while the woman has supported his professional and private requirements. In 20th Century Australia it has frequently been the norm that wives of medical practitioners give up thought of a career to support their spouse and tend to the family. However, many of these women were unprepared for the significant loss and isolation they experienced and they described "difficulty in maintaining a balance between their personal and professional life, yet they had a strong commitment to family life and the maintenance of their marriage" (Davis et al. 1988, p. 692).

Barbara McClintock (1902-1992) revolutionised the field of genetics through her observation of genes that could be transposed within chromosomes, and in 1983 she won the Nobel Prize in Physiology and Medicine. When McClintock was conducting

her research she frequently worked alone without the support of colleagues. Nevertheless, she "moved closer to the center of professional action than any other woman in her field" (Fox-Keller 1983, p.74). McClintock did not support female stereotypes and although she found the career of a research scientist difficult she believed that "when a person gets to know you well, they forget that you're a woman...the matter of gender drops away". She insisted on being evaluated by the same standards as her male colleagues and on equating merits with rights (Fox-Keller 1983, p. 76-77). Some medical women prior to the 1970s shared McClintock's conviction that gender issues were not a problem, yet they worked in a model of medicine that had been designed by men for the benefit of men.

When McClintock's reappointment in the Department of Botany arose she was considered not to be acceptable because her interest was entirely in research and the department preferred a "less gifted person, who would be content to accept a large amount of routine duty" (Fox-Keller 1983, p. 74). Unlike McClintock, the work of many medical women has been in routine curriculum and administration duties that were not seen to be heroic and prestigious. Lack of support for medical women academics has always been a significant problem when they seek equity with men.

Salner (1985) argues that women encounter bias when producing knowledge in academic environments, and strategies for producing knowledge are not gender-neutral. Women's contributions are frequently ignored and women are required "to think in ways that are male-oriented and discontinuous with their life experiences" (Salner 1985, p. 46). The assumption has been that women must adopt masculine

models that exist in the medical and academic world and leave their feminine ways of being at home.

By 1993 only nine women had been awarded a Nobel Prize as opposed to more than 300 men. A part of the explanation for this is that the first universities were monastic, organised by the Christian church to the exclusion of women. This segregation persisted in the academies and institutions that subsequently arose with modern science. The British Royal Society was established in 1662 and did not admit women until 1945. Before then the only woman in the Royal Society was a skeleton in the anatomy collection. Today 2.9% of the Fellows are female. The USA National Academy of Sciences has only 70 female members of 1,750 scientists (4%) as "there is still resentment between the old guard and the women...[and] it will change when [the old guard] die" (Holloway 1993, p. 97). The important question is, how to include women in organisations without having to wait that long.

A 1999 report on Excellence in Science prepared for the European Commission showed that under-representation of women and discriminatory old-fashioned employment practices were keeping the number of women in senior positions low. These practices related to reliance on patronage, the old boys' network and personal invitations to fill posts that cut across fair and effective employment procedures. "Scientist employers tend to be behind the times in addressing the life/work balance and need to modernise" (Loder 1999, p. 337). Historically the old boys' network has been an effective way of organising positions in the medical, academic and science domains and it is likely that this has had far reaching effects on the professional and

non-professional lives of WGPs. How effective the old boys' club is in medical practice today will be examined in this thesis.

In member States of the European Union, women make up less than 15% of full university professors and women are rarely on committees that set science policy. Private research organisations (such as the governors of Britain's Welcome Trust and the scientific advisory board of France's Association pour la Recherche sur le Cancer, as well as the board of governors of the European Commission's Joint Research Centers) have no female members. Loder (1999) thought that this had nothing to do with the role that women play in caring for their children and family but that "scientists have a special talent...for keeping women out" (Loder 1999, p. 337). Learned institutions are attempting to redress the balance by developing equal opportunity regulations. However achieving real change requires changing the culture, and since the existing culture has been arranged to advantage men, such change is difficult.

A 1999 report showed that women were under-represented in academic chairs in the Canadian Research Chairs program, since they comprised 25% of the academic pool yet occupied less than 15% of the 532 Chairs. Several universities had not appointed a single woman. As Vice President of the women's issues network at the Humanities and Social Science Federation of Canada, Robbins pointed the finger at the old boys' network of deans and academic Vice Presidents (Kondro 2002, p. 2319). While women in science and medicine may have an increasing presence in academic institutions they are still found at the lower levels of the organisation, performing

teaching and administration of the set courses in the educational program.

A 2002 report of the Helsinki Group, a European Union research organisation, showed that few countries have made science hospitable to women. Women are poorly represented on science and engineering faculties, the glowing exception being Portugal with women comprising almost half of its faculty members. The Netherlands is at the other extreme with an 8% female representation (Holden 2002, p. 41). A 2005 report on a government sponsored UK study designed to advance women's careers in science and in the University of East Anglia found that women in research institutes have higher career aspirations than men, but when these women apply for group-leader and senior management positions they get less encouragement and support from tenured researchers and department heads. As noted in this report:

> The sad fact is those [women] further down the scale are still not rising to more senior positions with the same frequency as men despite a clear desire to do so (Anon 2005, p. 792).

A USA National Academy of Science 2002 report showed that although women have increased in the scientific community they still lag behind their male colleagues in attaining full-time tenure track positions (Anon 2001, p. 386). In Japan women comprise less than 10% of the upper levels of industrial laboratories and universities. The Chemical Engineers for example have 2% female representation and admitted that they had never thought about building a society based on equal participation by men and women (Cyranoski 2002, p. 768).

The paucity of women in high professional positions in academia is widespread. A 2001-2003 survey of women in the 'top 50' academic departments in the USA revealed that female full-professors reached a 'high' of 4.8% of the total in the discipline of biology, and a 'low' of 4.4% in the discipline of chemistry. The discrepancy was highlighted by the relative percentages of graduating female PhD candidates in these disciplines over the same period, of 45.9% and 25.0% respectively. The barriers identified by the authors were 'pipeline problems', unconscious bias, problems of balancing family and work, hostility from colleagues and a 'chilly campus climate' (invisible to many men), subtle exclusion from he department community and decision-making processes, as well as "slights, ridicule, and attention to women's sexuality in professional settings" (Handelsman et al. 2005, pp. 1190-1191).

Very similar problems and barriers have been reported for medical women academics in the UK, with the problem of female recruitment to academic medicine being "likely to become more acute unless women's needs can be accommodated in more flexible career pathways" (Allen 2005, pp. 570-571). In Australia there have been an increasing number of women in medicine and General Practice training as shown by the demographic data in Chapter 2. The barriers and problematic issues for those WGPs seeking senior professional positions in Australian medical organisations and in academia will be explored in this thesis.

From the 1970s affirmative action was taken in the USA to increase the number of women in academic science departments. However subsequent lack of enforcement

reduced the spirit of the law to paperwork, often with little or no effect on female recruitment and no impact on female retention. A policy of affirmative action has not been adopted in Australia to increase the number of women in academic medicine and science, although there have been moves in that direction, and tokenism is common. The barriers and problematic issues that exist to discourage Australian academic WGPs will be explored in this thesis.

Many university departments aggressively court a few female stars, while discrimination continues for most. The ability of university departments to defend traditional academic practices as being gender neutral should not be underestimated. These Departments often resort to the argument that what goes into the pipeline will come out the other end. The attraction of the pipeline effect is that

> ...blame is firmly attributed to "the victim" who is expected to fix things; it removes responsibility from organizations and allows the *status quo* and the power structures to continue unchallenged (Sinclair 1998, p. 132).

At the European Young Investigators Awards (2005) only three of the initial 25 recipients were women, even though a quarter of the applicants were female. Watson *et al.* comment that "the statistics are clear: the consistent attrition of women at each stage, and the large size of the sample, mean that women's lack of success cannot have occurred by fluke. The random chance probability of halving the female fraction from one end of the competition to the other is only 0.05%" (Watson et al. 2005, p. 174). In order to explain this Watson *et al.* were "seeking a leaking pipe in

the stages of the competition" and called for further independent scrutiny to uncover the cause of this discrepancy (Watson et al. 2005, p. 174).

It appears that creating female friendly environments to attract and retain women in science and medicine still requires further attention. A 2006 survey of the Physics departments in UK and Ireland showed that while the number of female undergraduates had increased, signs of institutional sexism were found in offensive posters. There were few, if any, women speakers at seminars, and little effort was made to recruit women physicists. None of the departments had female heads and only 4% of tenured physics professors were women (Smaglik 2006, p. 812).

When reviewing the situation regarding women in science Kamens and Yee (2006) noted that statistics showed that there is a continuing need for institutional change as well as ongoing education on gender equality (Kamens and Yee 2006, p. 839). An examination of medical organisations and Colleges and their views of future change are provided in this thesis.

### 1.2.2 Medical Women in Research

The slow progress of women gaining higher positions in science is sometimes attributed to their having multiple roles, including being a partner and mother. Cole and Zuckerman (1987) showed that science and motherhood can mix and that women scientists who marry and have children publish as many papers per year, on average, as single women. Marriage, motherhood, managing a family and a research program

requires a woman to arrange her life and adapt to the circumstances. Marriage and children have an effect on the careers of women, but generally do not take their toll on their research. How do men achieve higher publication rates than women over the course of their career? If the answer is not explained by marriage and motherhood is it then explained by the discrimination of women? As Cole and Zuckerman suggest, these questions demand further comparative inquiry into the research careers of men and women (Cole and Zuckerman 1987, pp. 86-89). Such questions are addressed in this thesis.

Women in medicine and science have found that the peer-review system is flawed. While being the centre-piece of the modern scientific review process, the peer-review system has been criticised as having poor interviewer reliability and because reviewers may favor projects confirming their own views. Swedish researchers produced direct evidence that the peer-review system is subject to nepotism (Wenneras and Wold 1997, p. 343), their work strongly suggesting that reviewers could not judge merit independent of gender and that reviewers overestimated male achievement and/or underestimated female performance. It was also shown that a woman applicant could make up for her gender by being affiliated with one of the reviewers. This research concluded that if gender discrimination is operative in peer reviewed systems and other research bodies and grant awarding organisations, this could account for the lower success rate of female relative to male researchers. The credibility of the academic system will be severely undermined if a peer review system resistant to the weaknesses of human nature is not developed. However such a process requires the abandonment of secrecy by those who are in the club

(Wenneras and Wold 1997, pp. 341-343).

Since academic advancement is driven by peer-reviewed original research Jagsi *et al.* (2006) sought to determine the representation of female physician investigators among the authors of selected international publications during the past 35 years. Their study showed that although there had been an increase in the proportion of women among both first and senior physician authors of original research in the USA, women still comprised a minority of the authors of original research and guest editorials in the journals studies. Further investigation including qualitative studies is necessary to more fully understand the cause for this gap. Jagsi *et al.* summaries the barriers to female research as including the existence of traditional sex roles, sexism in the medical environment, lack of effective mentors, inequality in the provision of research resources, lack of salary and outside professional activities, family responsibilities, lack of positions of influence, high teaching and clinical loads, and a lack of women with internally recognised research and publication expertise. These barriers impede women's participation as authors and in turn may diminish the pool of female senior female academics who are eligible to serve in prominent authorship positions (Jagsi et al. 2006, pp. 285-286).

Women in science are in a similar position and the paucity of female editors points to the need to encourage the scientific careers of women, as it is likely that more senor women scientists will change the imbalance of female authors in scientific publications (Otto 2006, p. 812).

### 1.2.3 Conflicting Priorities for WGPs in Future Generations

Senior female scientists typically share the values and work styles of older men but the narrow focus of these men fail to meet the needs of younger women (Etzkowitz et al. 1994, p. 51). The role of women in science is claimed to split along generational and gender lines; as long as society is willing to accept a workplace organised on support structures provided to male scientists by unpaid full-time housewives, gender issues will not be seriously considered. The same issues apply in the case of wives supporting husband medical practitioners.

Isolation and loneliness in their work and in their private lives poses a problem for women in science and medicine. One reason for the continued isolation of a female scientist is that she is channeled into becoming either 'the traditional male' or 'the relational female' (Etzkowitz et al. 1994, p. 52). Likewise medical women may embrace the traditional masculine model of clinical practice, become housewife-supporters of their partners, or break the mould and find more suitable alternative models of working. This thesis will investigate to what degree the third option is relevant for WGPs who work in clinical practice on a part-time basis.

Historically women in science and medicine generally waited until they have achieved tenure to marry and/or start a family. They struggled to find the best time to schedule their pregnancies in the face of a rigid academic career structure that demands early achievement. Their career formed only one part of their identity and they strived to balance the demands of career and family.

Integrating science or medicine with personal life remains difficult for women students as university policies and programs regarding child-care or parental leave are often missing or inflexible. WGP registrars also have this dilemma as they progress through their General Practice training. How they achieve balance in their professional and non-professional lives is a key question examined in this thesis.

Younger graduates may no longer share the values of the generation before them, or the culture of the organisations that is their heritage. The difference between the older and younger medical generation must therefore also be explored to elucidate the future for the medical profession and its organisations. Generational change is pertinent to the future of General Practice in Australia and will form part of the present thesis.

### 1.2.4 Harassment, Discrimination, Bias and Micro-inequities

Over the last three centuries women in science and medicine have suffered derision, sexism, sexual harassment and discrimination. In the late 1880s, following a series of studies on the size of women's brains the English scientist's view of women's intellectual powers was summed thus: "It must take many centuries for heredity to produce the missing five ounces of the female brain" (Holloway 1993, p. 71).

Walter Channing, a professor at Harvard Medical School claimed in the1820s that it would be impossible for a woman to submit to the rigors of medical training because the female psyche could never stand up to such a demanding career and

"womanliness" would be completely destroyed. He argued that the female personality was entirely distinct from that of the male, reflecting what historians have referred to as the "cult of true womanhood" (Walsh 1990, p. 303).

Another Harvard Medical School Professor wrote in 1873 that the end result of medical education for women would be "monstrous brains and puny bodies" (Wynn 2000, p. 668), while Horatio Storer, a gynecologist in the 1860's, maintained that menstruation lead to "periodic infirmity...mental influences...temporary insanity", going on to ask who could trust the great questions of life or death to one whose equilibrium varied from "month to month and week to week...up and down"? In his opinion women were crippled because of their biology and certainly more in need of medical aid than being able to deliver it to patients (Walsh 1990, p. 303).

The ridicule directed towards women was reinforced by sexism that continues to occur in medical education. In 1974 the Harvard Medical School identified discrimination practices such as role stereotyping, sexual innuendo and ignoring females in a group situation. In the same year Dr. Estelle Ramey lead a successful battle to force Williams and Wilkins to withdraw its textbook *The Anatomical Basis of Medical Practice* containing pictures of nude females in seductive poses (Walsh 1990, p. 306).

Despite these examples of sexual discrimination there is continuing debate among medical women on gender discrimination, some denying its occurrence, others saying it has been eradicated (Lenhart and Evans 1991, p. 77). Certainly the

literature attests to ongoing sexism. Female medical students report being baited, taunted and teased by instructors, while sexist jokes in medical schools cause more isolation and stronger negative reactions for females than males (Hoferek and Samowski 1981, p. 398). Demeaning attitudes about women medical students are similar to those about women patients, and women students are targets for remarks that are hostile, belittling and ostracising (Howell 1974, p. 305). Women students report that there are frequently inadequate facilities such as lockers, toilets, showers, athletic equipment or space for sleep when they are on hospital night duty. They feel unwelcome, belittled and forgotten, and respond by denying the essential cruelty of this atmosphere and by demeaning themselves (Howell 1974, p. 306).

A definition of terms and concepts helps one to understand the professional and personal impact, the legal implications, and methods of coping, with gender bias and gender discrimination in the workplace. Gender bias refers to situations in which men and women are treated differently. The impact of this differential treatment can be positive, negative or neutral. Gender discrimination is used to describe behaviours, actions, policies, procedures and interactions that adversely affect a woman's work due to disparate treatment or the creation of a hostile or intimidating work or learning environment (Lenhart and Evans 1991, p. 78).

According to Lenhart the term micro-inequities describes activities and situations that are non-actionable but are unfair, inappropriate, painful or destructive. These events occur at the individual level and include conscious slights, invisibility and exploitation. Power and status are absent and micro-inequities and sex role

stereotyping has been applied to women in science and medicine over the centuries. Characteristic female traits such as flexibility, empathy, cooperation, and social consciousness are devalued. It would appear that qualities of dominance, ambition, and independence are essential to high office in medicine. Low-status subordinate roles require sensitivity, responsiveness, deference, and accommodation (Lenhart 1993, p. 156).

The extent to which WGPs have been subjected to harassment and gender discrimination and the effect that such discrimination has upon women who are considering becoming GPs will form part of this thesis. How micro-inequities affect those medical women who are current GPs will also become apparent.

### 1.2.5 The History of Women Doctors in Organisational Positions of Power

In Australia power is collectively held within the Church, education system, legal system, political parties, public service, business organisations, trade unions and the media. Usually men hold the top positions and women who attain high rank in these institutions (including medical) are considered stars in the firmament (Wearing 1996, p. 77).

Between 1998 and 2000 WGPs were elected as leaders of three major medical organisations in Australia, no woman having previously held these positions. The author of this thesis was elected President of the Royal Australian College of General Practitioners (RACGP) (1998-2000), Dr Karen Phelps was elected as the president of

the Australian Medical Association (AMA) (2000-2003) and Dr Lexia Briant was elected President of the Australian College of Rural and Remote Medicine (ACRRM) (1999-2000). Dr Julie Thompson was the first female national chairperson for the Australian Divisions of General Practice (ADGP) (2000-2002).

More recently Dr Sue Page was the first national President of the Rural Doctors Association of Australia (RDAA) (2003-2005), Dr Jennifer Thomson was chairperson to ADGP (2005-2006) and Dr Vasantha Preetham is currently President of the RACGP (2006). In the broader sphere of medicine, Dr Anne Kolbe became President of the Royal Australasian College of Surgeons in 2003, she being the first woman to become head of a surgical College anywhere in the world.

In academia no woman has been a Dean of an Australian medical faculty and there are currently only four WGPs with the title of professor in Australian universities. In contrast, in 2005 four male professors of General Practice were appointed deans or pro-vice-chancellors of Australian medical schools (Kamien 2005, p. 91).

### 1.2.6 The Historical Status of Women in Rural Australia

It is important to have an understanding of the historical background regarding the status and issues of concern for women living in rural Australia, particularly since a number of the participants in the research in this thesis practice as rural WGPs

Dempsey (1993) described the place of women in a small rural Victorian town he

called 'Smalltown'. After fifteen years of observation he found the subordination of women in the public sphere to be the norm. Women took part in organisations only on male terms and in an auxiliary capacity, primarily to raise money for men's sport or other male status-enhancing activities. This was classically demonstrated in an advertisement in a local newspaper in 1986, asking women to join the auxiliary for the local football club:

> Ideal candidates would be mothers, wives or girlfriends of players...main activities throughout the season will be the stocking and manning the canteen at the Smalltown football grounds (Dempsey 1993, p. 281).

Dempsey showed that rural women are disadvantaged by community mores and expectations that prohibit the economic independence gained by working outside their home. This situation reinforces the social division of domestic labour, with the needs and interests of their spouse and children being put before their own.

Women were excluded from facilities in Smalltown, the men claimed that women and their activities were inferior, women's comments were ignored, and during mixed conversation, men talked over them, especially when the conversation centered on men's affairs of work, sport or politics. Women were expected to *listen* to men. Men's work was superior to women's labour, be it domestic or paid. The work of men was thought to be more important economically for the family and community and more physically and emotionally demanding with greater responsibility.

Younger women in Smalltown resented their subordinate position and the exploitative nature of the men and organised women's groups to overcome the isolation, loneliness and boredom. These women also refused to join auxiliaries and service organisations. They attempted to negotiate with their husbands a more equitable distribution of domestic tasks and child-care, but a husband who agreed to this would appear as failing to control his wife (an important norm in Smalltown). Dempsey thought that change could not occur until paid labour, the domestic division of labour and the system of inheritance in rural Australia is reorganised (Dempsey 1993, pp. 287-294).

Alston's 1995 rural study on the changing role for women on farms gave similar findings except farm women had moved from a traditional sexual division of labour, where each partner operated in their own area, to a more flexible allocation of labour outside the household. Despite this the realignment of domestic responsibilities had not taken place, leaving women to work both inside and outside the home. Alston's study shows that change for farm women will be slow because they internalise their own subordinate position in society and undervalue their own effort. The marginalisation and undervaluing of women was aided by their lack of resources or of positions of power within their communities. Both Alston and Dempsey claim that to challenge cultural norms and historical processes invites conflict within the family and community. "The challenge to patriarchy must come not from individuals but from the community itself and from government instrumentalities" (Alston 1995, pp. 147-150).

# Section 3

## 1.3 The History of Pioneering Medical Women

### 1.3.1 Pioneering Medical Women in America

#### 1.3.1.1 Introduction

The history of pioneering medical women in America gives an insight into prevailing social and professional conditions that also prevailed in other Western countries. Women were excluded from studying medicine until the mid 19th Century and significant barriers existed to practicing medicine if they managed to qualify. As physicians they were commonly restricted to caring for women, children and disadvantaged social classes. Some found a niche in health education but since medical men had little regard for their professional status women physicians were unable to find positions in renowned medical establishments.

Medical women in that era endured derision from male students, male medical professionals and indeed sometimes from other women who regarded them as "crazy". They were subject to patriarchy by male physicians who denounced their medical and professional abilities and capacity to achieve eminence in the profession or to be "fit to practice medicine".

Sometimes a male-dominated profession can raise an individual woman to the highest level. This was the case with Professor Mary Putnam Jacobi who was prominent in the medical profession through her publications and her clinical work.

### 1.3.1.2 Elizabeth Blackwell

Medical women in the USA have been involved in a struggle to be accepted that lasted more than 150 years. In 1847 Elizabeth Blackwell was the first woman to gain entrance to a medical school (Geneva Medical School) in the USA (Fletcher 1982, pp. 2-3). When she applied to study medicine the professors referred her application to the fee-paying male students who thought it was a hoax and voted to accept her never thinking she would accept. *The Boston Medical and Surgical Journal* and *The Buffalo Medical Journal* both reported this unusual occurrence. However, they noted that Blackwell's presence in the classroom resulted in far better observance of decorum than usual, and the anticipated embarrassment at having a woman in the class when discussing "matters of delicate nature" soon disappeared (Bernstein 1992, pp. 17-19).

Blackwell later revealed that in 1845 she wrote to six eminent physicians asking for their advice about obtaining a medical education. She recorded that they

> ...all united in dissuading me stating that it was an utter impossibility for a woman to obtain a medical education. The idea though good in itself, was eccentric, utopian, and utterly

impractical (Bernstein 1992, p. 19).

When Blackwell finally entered the Medical College the town ladies pronounced her undertaking "as crazy or worse and declared they would die rather than support a woman physician" (Bernstein 1992, p. 19).

After receiving her medical degree in 1849 Blackwell faced many barriers from the medical institutinns when she applied for a position as a visiting physician in a hospital women's ward and dispensary. She encountered social and professional antagonism and "found herself without the support, respect, or professional contact so important in managing difficult medical cases" (Bernstein 1992, p. 19). Blackwell did what many medical women in the future would do to solve the problem of setting up a practice. She set up an office in her home and in 1859 was the first woman physician to be placed on the British Medical Register. However, in the next year the British Medical Association ruled that holders of foreign degrees could not be allowed to practice medicine in England (Miller 1994, p. 173).

### 1.3.1.3 The Hunt Sisters

The sisters Harriot and Sarah Hunt were the first women physicians in America in the early 19th Century. They suffered many slights from their Boston acquaintances and were the butt of jokes and criticism from the male medical profession. Seeing that Harriot Hunt advertised herself with the title of M.D. the editor of one medical journal, published an article implying that she knew little about anatomy even though

Harriot had earned a honorary Doctor of Medicine degree from the Women's Medical College of Pennsylvania in 1853 (Bernstein 1992, p. 18). These sisters represented the first generation of women physicians who strove to establish themselves as professionals.

Harriot devoted her work to women and children and encouraged other women to enter medical practice and focus on the health education of women in disadvantaged social classes. During the 1970s the second wave of feminism also stressed the need for educating women on the anatomy and functioning of their bodies. It has taken from the time of the Hunt sister until the 20th Century for the health education of women to become mainstream.

#### 1.3.1.4 Mary Putnam Jacobi

Mary Putnam, later Putnam Jacobi by marriage, entered the New York College of Pharmacy in 1861 and graduated with honours in 1863. She matriculated in medicine from the Medical College for women in Pennsylvania in1864 aud from the École de Medicine (Paris) in 1867 with the highest honors. Mary returned to New York in 1871 with what Sir William Osler described as a "Paris medical degree and a training in scientific medicine, unusual at that date even among men" (Bernstein 1992, p. 21).

Mary became prominent in the medical profession writing books and papers and conducting busy clinics at major hospitals. She taught at The Women's Medical College of the New York infirmary and in 1872 became a professor. She was the

first woman inducted into the New York academy of Medicine 1880 and the first woman of the New York Infirmary in 1872. After her death in 1902 Sir Osler delivered this testimonial:

> The scientific character of her numerous contributions gave a new distinction to the work of women physicians in this country and contributed not a little to allay the strong animus which for so long kept them out of schools and medical societies. That almost everywhere the door is now open is due largely to the influence exerted unconsciously in this woman (Ruben 1972, p. 253).

William Osler perhaps had more influence on medical training in England and North America than any other physician at the turn of the 20th Century, and had previously actively prevented women from entering Medicine. He believed women were not up to professional demands and joked with his students in 1893, that "human mankind may be divided into three categories; men, women, and women physicians" (Pringle 1998, p. 28).

The number of women entering medical school in the USA steadily grew in the mid-1800s, particularly in schools established specifically for women since they were not well accepted by male-dominated medicine. In 1871 a group of women sought admission to the American Medical Association. The president, Dr. Alfred Stille acknowledged that women had a right to study and practice medicine, but he predicted they would never become eminent in the field. He claimed that some

medical societies, invoking ethical concerns, made it their official policy to forbid members to consult with women physicians because

> ...women were too uncertain in judgment, capricious in sentiment, fickle of purpose, and indecisive in action to be fit to practice medicine [and]...they lacked the moral sense to fulfill a contract (Bernstein 1992, p. 21).

By the late 1800's women working in medicine had gained a modicum of acceptance. Some assisted in water therapy, some provided education in girls' schools or to women's groups, some worked with their father or husband and some were allowed to follow staff physicians on hospital rounds (Bernstein 1992, p. 21).

The exclusion of medical women in America had begun before the publication of the Flexner report in 1910 that recommended that most of the American medical schools should be closed because of an oversupply of physicians. Not surprisingly therefore, women were the primary targets among those considered superfluous (Lorber 1991, p. 33).

### 1.3.2 The History of Pioneering Medical Women in Britain

#### 1.3.2.1 Introduction

The early medical women of Britain paved the way for medical women pioneers in Australia. A British woman who sought to become a physician in the early 19th

Century was the victim of discrimination and was regarded "partially as a student" or an "amateur". Male students and lecturers were intolerant of the suggestion that women examine or dissect bodies, studied anatomy, or took part in the examination process. Lectures and exams were viewed as the property of gentlemen and support for this concept came from the public, media and prominent hospitals that campaigned against women studying or practising medicine. Possibly the men were reluctant to share the power and prestige that they enjoyed as physicians with women or possibly it was blatant sexism. The upshot of the situation that confronted women was the establishment of a School of Medicine for Women in association with a London Hospital for the treatment of women.

Even during the two World Wares commissions, uniforms, badges and the rank of officers were withheld from women doctors. Not until the 1950's did this situation change. Despite women doctors gaining a firm foothold in clinical medicine they remained excluded from the masculine dominated British Medical Associations for many years. As is shown in the next section of this Chapter some British women doctors became the medical pioneers of Australia.

### 1.3.2.2 Elizabeth Garrett Anderson

In the 19th Century medical practitioners had to qualify in Britain to work in Britain. Medicine was reserved for men and when Elizabeth Garrett Anderson applied for entry the Treasurer of the Middlesex Hospital Medical College told her that

> ...he would not allow [her] to pay any fees as that would be recognizing [her] partially as a student but [she] may make a donation to the hospital and stay through winter learning all that she can as an amateur (Evans 1978, p. 7).

He said it was impossible for her to gain entry to the College, as a lady's presence at lectures would distract the other students' attention. The male students signed a petition for her dismissal from the College on the ground that future doctors would not accept a woman examining bodies. The universities of London, Oxford, Cambridge and St. Andrews all turned down her application, so she instead gained a diploma of the Society of Apothecaries, since a person holding this diploma could set up as a doctor. She also took private lessons with university lecturers and one lecturer replied to her approach for lessons by saying:

> I must decline to give you instructions in anatomy. I have so strong a conviction that the entrance of ladies into dissecting-rooms and anatomical theatres is undesirable and highly unbecoming that I could not do anything to promote your end...Ladies would make bad doctors (Evans 1978, p. 8).

Elizabeth's name was entered on the British medical register as a doctor in 1866 and she also passed her degree of Doctor of Medicine in Paris in 1870. In 1874 she joined the council for the London School of Medicine for Women, helping to bring about the 1876 law allowing all medical examiners in Britain and Ireland to accept and graduate women. In 1878 the London University opened all its degrees including medicine to women, however for the next 19

years their entry to the British Medical Association was barred (Evans 1978, p. 8).

Elizabeth became the Dean of the London School of Medicine for Women, which is now known as the Royal Free Hospital Medical School. She established a dispensary where women doctors cared for women and this subsequently became the Elizabeth Garrett Anderson Hospital in Euston Road London.

#### 1.3.2.3 The First Women at Edinburgh

In 1869 Sophia Jex-Blake, Elizabeth Thorn, Edith Pechey and three other women became the first women medical undergraduates in Britain. At the Edinburgh Medical School when the women sought to enter the required course in anatomy in their second year, they found their way blocked by male students who barricaded the doors to the hall, threw mud at them and shouted obscenities. When the women made their way into the teaching hall, they found their male classmates had placed a sheep in the room explaining that they understood that now 'inferior animals' were no longer to be excluded from the classroom (Miller 1994, p. 173). The London Times wrote that the strongest argument against the admission of young ladies to the Edinburgh medical classes was that they would attend the lectures of gentlemen (Leeson and Gray 1978, p. 25).

The managers of the Edinburgh Infirmary were petitioned to refuse the admission of

women to the wards and a riot was staged outside a hall where the women were sitting examinations. The university won a lawsuit that allowed them to refuse women their degrees and so the Edinburgh University had taken the women's fees but found it could not graduate them. This resulted in the establishment of a women's medical school in London in 1874.

#### 1.3.2.4 Pioneering Women in Military Medicine

During the First World War (1914-1918) the War office refused the service of a group of women doctors offered by the National Union of Women Suffrage Societies. As a result these societies, together with the Women's Social and Political Union, sent units to France and Serbia independently. Later women doctors were reluctantly taken into the Army Medical Services, but without commissions or badges. During the Second World War the Royal Army Medical Corps gave women doctors a contract of service, but not a commission with the relative rank of officer, a uniform or badges. Not until 1950 were women commissioned in the Royal Army Medical Corp (Leeson and Gray 1978, p. 26). It appears that unlike James Barry who was successful in military circles when dressed as a man, when women doctors dressed as women their admission to a senior military rank was slow or impossible.

### 1.3.3 Pioneering Medical Women in Australia

#### 1.3.3.1 Introduction

The early pioneering medical women who applied for medical registration in Australia had usually gained their medical education and experience in America or Britain. Their stories illustrate the strong link that existed between these countries and Australia at that time. Initially medical women who tried to work in Australia were met with a barrage of patriarchy, discrimination and exclusion. They were cast in the role of imported medical curiosities and prompt refusal was given to their applications to work in Australia as doctors. In 1890 the first woman doctor commenced practice in Australia. When Australian medical schools were established women were debarred from admission. Some women doctors qualified overseas and in time the medical schools commenced accepting female students. Female medical graduates were however still rejected from positions as hospital medical officers.

Generally women doctors conducted their work in the community, and made significant contributions to caring for the health of women and children. They also performed other work including missionary work, aboriginal health, public health, immigration and preventative health services. In rural and remote areas their extensive medical contributions were appreciated as they offered a full range of services including obstetrics, anesthetics, surgery and internal medicine. In addition many medical women showed leadership in local public affairs, universities, government medical positions and research, as well as keenly supporting young

female medical students. Generally female doctors were not competing with male doctors for power and prestige in senior posts in renowned hospitals and universities. However, women doctors are credited with the establishment of a hospital in Sydney and Melbourne in order to care for women and children, especially those from poor and disadvantaged circumstances. These hospitals have evolved over time but are still supplying hospital medical services to the community.

The downside of being a woman doctor in the 19th Century and much of the 20th Century was discrimination, lack of equal pay, difficulties in providing child-care and domestic help, lack of safety in the professional workplace, lack of equal opportunity and having to resign from a public service job at the time of marriage.

Women doctors commonly worked flexible hours, or part-time, or temporarily retired from medical work to resolve their family and domestic circumstances. They employed domestic help and child-carers in their homes. The recognition of the dedicated services of early medical women was slow but eventually honours flowed to some. What is striking is that early women doctors were key participants in the history of General Practice in Australia and the history of their lives alerts us to issues that are still common in the lives of WGPs.

### 1.3.3.2 First Female Applicant for Australian Registration

In1865 Wilhelmina Ferguson, a ship's surgeon on an American freighter, was the first woman to apply for medical registration in Australia. The Victorian Medical

Board refused her application and referred her case to the Crown Law Department. Despite the support of the Victorian Attorney General her application was turned down (Sandford Morgan 1970, p. 6). The editor of the Australian Medical Journal wrote of behalf of the (male) medical profession:

> If Ferguson favorably impressed our legal experts, she produced quite the opposite effect on the medical profession...The application comes from America where women insist on doing what is done for them in less advanced communities and a woman who voluntarily devotes herself to a state in which the abandonment of the domestic qualification seems a necessity, is a being who men do not love and with whom women can hardly sympathize...But there is little fear that in any British community medical women will exist as a class. They will occasionally be imported, like other curiosities, and the public will wonder at them just as it wonders at dancing dogs, fat boys and bearded ladies, and, in accordance with the demand for novelties, they will, perhaps, be successful in a material sense, but they are not likely to be included in the list of the British institution (Sandford Morgan 1970, p. 6).

These harsh words exemplify nf the role that men expected women to fill at that time. In 1885 another female American doctor, Laura Morgan, was also refused registration in Victoria. Medical Boards of each State still have the power to determine a person's eligibility for registration as a medical practitioner and at the time when Laura Morgan applied for registration, being a woman was sufficient reason to disallow her registration.

### 1.3.3.3 First Registered Female Practitioner in Australia

In 1890 Constance Stone became the first woman to practice medicine in Australia and the first woman to be registered in Australia (Victoria). Constance was an American graduate from the Women's Medical College in Philadelphia, a respected institution that had admitted women for over 30 years. Having been refused entry to the University of Melbourne, she obtained a M.D. as well as a British degree in Toronto, Canada, and in London the Licentiate of the Society Apothecaries, the only qualification open to women at that time in Britain. Constance practiced as a GP in Melbourne until her death in 1903 (De Vries 2003, pp. 100-105).

### 1.3.3.4 First Female Medical Students

The University of Adelaide agreed to the admission of women to medicine in 1874, although no woman enrolled for many years. In 1886 Laura Fowler entered the medical school of the University of Adelaide and graduated in 1891. She and her husband Dr Charles Hope worked as missionaries in India and during World War I both were permitted to join a Scottish Women's Hospital Service in Serbia where they were taken prisoners and interned. On their release they returned to medical practice in South Australia (Sandford Morgan 1970, p. 8).

Dagmar Berne was the first Australian woman to enrol in medicine at the University of Sydney in 1883. She completed four years of the course and then transferred to Great Britain obtaining a Licentiate of the Royal College of Physicians (LRCP) in

Edinburgh and the Licentiate of the Surgical Association (LSA) of London. She died in Sydney in 1900 of T.B. at the age of 34. The first women to finish the medical course in Sydney were Isa Coghlan and Grace Robinson in 1893 (De Vries 2003, pp. 95-100).

In 1887 seven women were accepted to study medicine at the University of Melbourne, while Clara Stone and Margaret Whyte were the first women graduates from that University in 1891, the last two women of the group graduating in 1894 (Sandford Morgan 1970, p. 12).

Medical schools were subsequently opened in Queensland (1939), Western Australia (1956) and Tasmania (1963). By the mid-20th Century female medical students were well integrated into medical schools throughout the country.

**1.3.3.5 Early Female Appointments to Australian Hospitals**

The early medical women medical graduates had problems in gaining appointments in Australian hospitals. Margaret Whyte topped the honors list in medicine and surgery in 1891 but because of her sex was refused a resident's post at the Melbourne hospital. Not until 1896 were Janet Greig and Freda Campbell granted Resident Medical Officers posts at the Melbourne Hospital. In 1905, the public outcry following the refusal to appoint women doctors to the Sydney or Royal Prince Alfred Hospitals resulted in the appointment of Jessie Aspinall for a year. In 1909 all restrictions to women's appointments to resident medical officer posts in teaching

hospitals in Sydney were lifted (Sandford Morgan 1970, pp. 11-12).

The Royal Adelaide Hospital had always taken women graduates including those refused entry to posts in Sydney and Melbourne. As recently as 1955 the Royal Adelaide Hospital refused admission to three women graduates. However, the South Australian Medical Women's Society, supported by public opinion vehemently voiced opposition to this decision, resulting in its prompt reversal.

### 1.3.4 Some Notable Early Women Practitioners in Australia

#### 1.3.4.1 Lilian Cooper

The first woman registered in Queensland was Lilian Cooper in 1891. Lilian was a Member of the Royal College of Surgeons (MRCS) and Licentiate of the LRCP from Edinburgh and Glasgow and she came to Brisbane with a companion, Josephine Bedford. Lilian built up a surgical practice in Brisbane and during the First World War she served as a surgeon in a British Hospital in Serbia. (Sandford Morgan 1970, p. 15).

#### 1.3.4.2 Eleanor Bourne

Eleanor Bourne was the first woman Queenslander to study medicine, graduating in Sydney in 1902. On returning to Queensland she became the first woman Resident Medical Office at the Brisbane Hospital and later was superintendent of the Brisbane

Children's Hospital. She was also the first Medical Inspector of schools in Queensland and her travels throughout the State gave her the opportunity to perform outstanding research on hookworm infestation. In 1916 she worked in London at the Endell Street Military hospital, staffed entirely by women. She rose to the rank of Major and after the war she obtained a Diploma of Public Health in London and worked as an Assistant Health Office in the City of Carlisle. On returning to Brisbane, she played a leading part in the establishment of the University of Queensland's Women's College (Sandford Morgan 1970, pp. 15-16). Eleanor's career demonstrates the variety and flexibility of jobs held by pioneering medical women.

### 1.3.4.3 Amelia Corlis

In 1896 Amelia Corlis, a Canadian, became the first medical woman to become registered in Western Australia (WA), setting up practice with her husband, Josiah on the Bellinger River in 1892. During the gold rush an epidemic of typhoid facilitated their relocation to Southern Cross in WA. Subsequently they established practices in Port Augusta and in New South Wales (Sandford Morgan 1970, p. 16). This model of married GPs in practice together has been embraced by many others since.

### 1.3.4.4 Roberta Jull and Gertrude Meade

Roberta Jull was instrumental in founding the Western Australian Branch of the British Medical Association (BMA) in 1899. She subsequently established the Infant

Welfare Organisation and Baby Clinics in WA, was a member of the University Senate and Warden of Convocation, and contributed to the foundation of St.Catherine's a College for University Women. Gertrude Mead practiced in Perth, W. A. and was one of the first two women appointed to the newly founded University Senate in 1913 (Sandford Morgan 1970, pp. 16-18). The medical work of Roberta Jull and Gertrude Mead centred on the medical care of women and children, these continuing to be foci of attention for WGPs to the present time.

### 1.3.5 Pioneering Rural WGPs

#### 1.3.5.1 Alice Laverack

Alice Laverack graduated in Melbourne in 1909 and practiced in country Queensland. She made her calls on horseback carrying a 0.45 Colt revolver and found a riding-whip useful in dealing with drunken hospital patients. She had seven children and after the death of her husband continued as a country GP until 1950 (Sandford Morgan 1970, p. 19). Alice also cared for a large family and endured the rigors of rural practice at a time when communication was slow and difficult. Workplace safety was a concern for Alice, a concern that still exists for WGPs.

#### 1.3.5.2 Freda Gibson and Merna Muller

Freda Gibson was an Adelaide graduate, who held the position as the first medical

officer at the Flying Doctor Service at Ceduna in South Australia. In 1948 Merna Muller joined Freda and Merna continued the service after Freda retired. Their practice covered 200 000 square miles and the pedal wireless allowed them to conduct radio clinics with their patients. At sheep stations, a room in the homestead known as "the doctor's room" contained the facilities for consultations, minor surgery and a general anaesthetic if necessary. They often flew to see patients who were emergency cases, or had these patients transferred by air to one of the base hospitals. The Queen decorated both women for their work at Ceduna (Sandford Morgan 1970, pp. 21-25).

**1.3.5.3 Ellen Kent Hughes**

Ellen Kent Hughes commenced medicine in 1913 and bore a son to her first husband who died three months after she married. She took a job at the Brisbane Hospital for Sick Children while her baby lived in the resident's quarters. During the severe drought in 1919 Ellen worked as a locum at Mitchell 400 miles west of Brisbane. There was no other doctor for hundreds of miles and only two trains a week coming to Mitchell. Ellen married a local man and they had four children. Ellen worked until each baby was born and took a month off afterwards. Taking maternity leave is frequently a difficult issue for WGPs.

Ellen later worked at Kingaroy and in Armidale. She had many obstetric patients, provided surgery and internal medicine, and gave anaesthetics. She retired at 79 years and was made a Member of the British Empire in recognition of her community

service and her care for aboriginal children. She said that she wanted to study medicine but also wanted to get married and have children. She is quoted as saying:

> I would never have been able to have five children and run a full-time practice if I had not been blessed with a capable and faithful nurse-housekeeper and another maid as well. If a woman doctor wants to marry and have a family and carry on practice, she must employ good household help (McGregor Hellstedt 1978, p. 108).

Ellen's case underscores the importance of WGPs having household help and suitable child-care especially if they wants to continue full-time medical practice and raise children.

### 1.3.6 Hospitals Founded by Medical Women

Two Australian hospitals catering to the care of women and children were founded by women and staffed by women in the late 19th and early 20th Centuries. The Queen Victoria Hospital was founded in 1890 in Latrobe Street, Melbourne, an area with a poor population. The accommodation was dark, cold and without running water, which was drawn from outside and heated on a gas ring. The medicine was dispensed from the ticket office off the hall. The medicine bottles were collected, prepared and labeled by the doctors and in the first three months 605 women and children were treated. A new hospital opened in 1899, and there was a significant improvement as this hospital had beds, a clinic for outpatients and a dispensary.

Since then it has become renowned for high quality medical services having both males and females as staff and patients (Sandford Morgan 1970, pp. 39-42).

Lucy Gullet and Harriet Biffin established an outpatients department (originally a decrepit house) in the slums of Surrey Hills Sydney in 1922 and staffed it with medical women. Both women and children were treated and by the end of the first year 2 421 patients had been cared for. A venereal disease clinic was also established and as the hospital grew rapidly it was moved to the suburb of Redfern. The name of the hospital was changed from the New Hospital for Women and Children to the Rachel Foster Hospital, Lady Rachel Foster being the wife of the Governor General. It has become a public hospital and a training hospital for medical students and nurses and it has accepted male patients since 1967 and male staff since 1964 (Sandford Morgan 1970, pp. 43-47).

### 1.3.7 Further Stories of Medical Women

Women doctors in Australia have held diverse medical roles with a focus on women's health, infant welfare and health, community medicine, public health and preventative health. Medical women tended to work in professional areas where they had personal experience and where family-friendly hours were available. These areas of medicine were not areas men sought and the power and prestige found in senior hospital posts was not found in the provision of community medicine. Women doctors were employed in universities as well as in local government and local councils. They took a keen interest in

encouraging younger women who aspired to becoming doctors.

The Medical Women's International Association (founded in 1919), asked notable pioneer women doctors from around the world with birth dates between 1878 and 1911 to write their autobiographies and this collection of stories provides a rich source of information about their lives and experiences. Several of the women commented in their stories on discrimination they had experienced as doctors (McGregor Hellstedt 1978, p. xiv).

### 1.3.7.1 Elma Linton Sandford Morgan

Elma Linton Sandford Morgan graduated in 1917 in Sydney and was the author of *A Short History of Medical Women in Australia* published in 1970. Elma worked as a doctor in the eye hospital of London and in a mission hospital in the Punjab in India where the conditious for surgery were poor, water was brought from a well in goatskins and sterilisation of dressings and instruments was done on a primus stove. Hurricane lamps or lighted wicks in saucers of oil provided the lighting (McGregor Hellstedt 1978, p. 45.).

In 1920 Elma became the medical director of a Women and Children's Hospital in Mesopotamia (later Iraq). She conducted large outpatients, did all the surgery, took private patients and confined most of the British women. She married and did postgraduate work in Glasgow at the Women and Children's Hospital until 1926 when she became the first WGP in Hobart Tasmania, reporting that

> ...the conditions in the medical world in Hobart, the capital city, were very unsatisfactory, because the general hospital was presided over by a male unqualified doctor and was consequently out of bounds...(McGregor Hellstedt 1978, p. 46).

Elma was appointed director of the Public Health Department in New South Wales in1929, being the first woman to hold an executive position in the State public service. She said that her many activities were only possible because

> ...I had the good fortune to have reliable domestic help throughout the childhood of my daughter and son, so that during my enforced absences I knew that they were as well cared for as when I was at home (McGregor Hellstedt 1978, p. 46).

Elma moved to Adelaide to set up a mothercraft training school and perform as a locum GP. She joined the Royal Australian Air Force Medical Service during WWII and was the only woman appointed to a parliamentary commission to investigate health services in South Australia.

Elma was also appointed as medical officer within the Commonwealth Immigration Camps of Australia. The advertisement stated that such an appointment would make one eligible for a posting in one of the European countries. However after a year at the Bathurst camp of 5 000 migrants her application for a European post was turned down. The Commonwealth Health Authorities informed her that

> ...this reward for services rendered applied only to male doctors and that no medical women were employed in the immigration department's overseas recruiting center (McGregor Hellstedt 1978, p. 47).

Elma subsequently worked in radiotherapy in Adelaide to later become president of the Australian Federation of Medical Women (AFMW). She continued to play an active part in women's appointments to the Royal Adelaide Hospital and in gaining equal treatment for women resident staff.

Elma's story shows that it was possible for medical women to gain appointments in both private and public sectors, demonstrating leadership in providing health services and in professional organisations. She described how she managed to provide child-care and domestic help for her family at a time when medical women often gave up medical practice because of the lack of its flexibility and availability of child-care. During her career she received unequal pay relative to men for equal work. As she said:

> In all my years in medicine (at any rate in Australia) I have found that medical women have had to fight and still have to fight for their rights, especially as far as equal pay for equal work is concerned. [However I] feel I have had the best of two worlds, professional and personal (McGregor Hellstedt 1978, p. 48).

### 1.3.7.2 Women in the Professional Workplace

Ellen Balaam graduated in 1915 and Grace Johnston Cuthbert-Browne (who commenced medicine 1918) both claimed that being female had "been to their advantage" during their medical career. Lady Phyllis Cilento graduated at the end nf World War I and said that being a woman in the medical world was an asset. She always emphasised the women's point of view and the interests of women and children (McGregor Hellstedt 1978, p. 119).

In contrast Joan Refshauge who retired in1973 noted that "...although I did better in examination than some men, they had more and better opportunities open to them" (McGregor Hellstedt 1978, p. 337). Joan was refused residency at the Melbourne hospital, her old student training school, the male graduates objecting to her residency because she was married. She lectured in mathematics to engineering students but when she became a "married woman" she was forced to resign from this job. This was standard practice in the public service in those days and according to Joan, that was just a fact of life.

Joan was one of the first women to obtain a permanent position in the Public Service in the Territory of Papua New Guinea, but she received only a percentage of a man's wage and her superannuation was smaller than that of a man in her position. Joan's case exposes the lack of equal opportunity for women in the medical workplace and highlights the inequity of women's wages. The problem of inadequate remuneration for equal hours worked remains for WGPs to the present time.

### 1.3.7.3 WGPs Who Owned a General Practice

From the early 20th Century female doctors gradually came to own and operate their own practices. Christine Walch was born in Hobart in 1893, graduated in Sydney in1925 and returned to Hobart as a GP. She discovered that having an obstetric practice was mandatory and she was appalled by the lack of gynecological knowledge of the older male doctors.

Christine fostered modern approaches to medicine and pioneered ante-natal care which helped to reduce the maternal death rate in childbirth. Christine became an honorary Captain stationed in Hobart during World War II and retired in 1950. She made contributions to the University Council, the Women's Graduate Association and the Jane Franklin Hall, a women's residential college.

In 1954 Christine's practice in Hobart was taken over by Val Davenport who was born in 1922. Val served in the Air Force WWII and studied medicine at Melbourne University after the war ended. Val practiced obstetrics and introduced relaxation techniques during childbirth and ante-natal care classes. Val was also a driving force for the establishment of the Childbirth Education Association and the Family Planning Association.

Because of her heavy workload Val "collared" any available woman doctor to help her and in the late 1960's began a group practice with up to six female doctors working full- or part-time. The practice is still in operation and has continued to

provide an emphasis on women and their families. The structure of the practice changed from an associateship in which each WGP had an equal interest to a corporate body with some of the WGPs holding shares. The corporate body requires the WGPs to sign contracts as employees and two or three female practice shareholders acted as members of the board (Alexander 2003, pp. 23-33). This example exemplifies the change that is taking place in General Practice nationwide at the present time.

## 1.4 Conclusion

The appraisal of the lives of early medical women highlights the barriers and difficulties these women faced when fulfilling their roles as wives, mothers and medical practitioners. The struggles of these women to overcome the patriarchal mind-set of the day was difficult, with discrimination, harassment and bias continuing to challenge the position of women in their workplace and in medical organisations concerned with General Practice.

This Chapter provides an introduction to Chapter 2, which examines historical publications relating to the lives of Australian WGPs in order to gain a better understanding of the socio-political space WGPs occupy in the changing environment of General Practice.

# Chapter 2

# Women GPs in Australia: a Changing Environment

## 2.0 Introduction

This chapter reviews the literature (1970-2004) and demographics of WGPs in Australia. It also examines the historical changes in the Australian General Practice environment that have affected the lives of the WGP participants in this thesis. The socio-political space that WGPs have occupied in organisations and Colleges is also examined and this coupled with the knowledge gained in Chapter 1 regarding the lives of medical women as healers and pioneers, provides a foundation for the empirical studies reported in this thesis. Literature (2005-2006) regarding the lives of WGPs is examined in Chapter 3 in order to confirm the relevance of this research to the current lives of WGPs and the socio-political space they occupy in medical organisations and Colleges.

## Section 1

## 2.1 Changes in General Practice in Australia

In order to understand the structure, functioning and gendered nature of the General Practice environment in which the participants existed when the research data was

gathered (1996-1998), an examination of the major changes that affected General Practice since the 1970s is presented. Attention will be particularly drawn to the effects of these changes on the lives and work of WGPs.

### 2.1.1 What is General Practice?

The Royal Australian College of General Practitioner defines General Practice as:

> That part of the health care service in Australia that operates predominantly throngh private medical practices, which provide universal unreferred access to whole person medical care for individuals, families and communities. General Practice care means comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understanding of health (RACGP Online 2003).

The RACGP also states that the current accepted definition of a general practitioner in Australia is:

> A registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care and maintains professional competence for General Practice (RACGP Online 2003).

These definitions confirm the role of the GP as a generalist and although whole-

person care and social environment is acknowledged, the regulatory nature of qualification, competence and biomedical knowledge is integral to these definitions.

Strasser (1991) identified the defining characteristics of General Practice as including primary, continuing, comprehensive, community-based, patient centred and preventive care. These characteristics were said to provide General Practice with four key realities:

- A community spectrum of unwellness.
- Unselected patients with undifferentiated and unorganised problems.
- A high degree of uncertainty.
- Individual/personal commitment and responsibility to the patient (Strasser 1991, pp. 533-544).

The modern medical profession grew from three roots: the university trained physician, the craftsman barber/surgeon and the tradesman apothecary. The term general practitioner was first coined in 1823 but it was not until the latter part of the 19th Century that differentiation in role and function began to develop (Strasser 1991, p. 610).

General Practice is the "oldest branch of the medical profession...[but] a profession or a craft is not the same as a scientific discipline" (Gray et al. 1997, p. 139). Converting a professional group to a scientific discipline consists of "developing a unique body of knowledge and expounding it in scientific terms using methods that the scientific community can recognise as objective. This also means publishing

in...a peer reviewed scientific journal of the subject...A discipline is recognised by universities as a body of knowledge that can be researched and taught (professed) and is therefore worthy of a university chair...Citation of the work of those in the discipline by those in other disciplines [provides] independent evidence of scientific value" (Gray et al. 1997, p. 139). General Practice in present-day Australia functions as a recognised discipline and is the first port of call for most patients in the Australian health care system, with GPs acting as gatekeepers for entry into the secondary and tertiary health sectors. While a medical discipline is based upon science and evidence drawn from objective scientific scrutiny, the art form that is a critical part of healing of the sick and the gendered nature of healing is seen as necessary components of the knowledge skills and attitudes of a caring GP.

### 2.1.2 The Rise of Specialisation

Prior to 1930 doctors who specialised in Australia were experienced GPs who acted as consultants and filled senior posts in hospitals and universities. The independent medical practitioner performing General Practice while also working as a physician and surgeon was common until the 1940s. The Australian College of Physicians (established in 1938) and other specialist colleges encouraged specialist training to become more formalised and hospital based. The physicians and surgeons gradually established specialist hospitals, "laying the foundation for [their] dominance within the medical hierarchy as the custodians of medical knowledge" (Strasser 1991, p. 610).

From 1950 hospitals became the focus of new technology and teaching hospitals attached to medical schools attracted specialists. Medical knowledge increased in volume and complexity and specialist disciplines developed, growing in power and prestige. Gradually, General Practice experience was excluded (Power and Aloizos 2000, p. 158). The power of technology, science and the specialist disciplines moved much of medical care from the generalist to the specialist.

Also at this time most Australian medical graduates undertook a year as a resident in a teaching hospital, before spending several years in community-based General Practice. If a doctor then wished to specialise he/she would travel to the UK to gain the necessary experience, skills and qualifications. Upon returning to Australia the doctor would establish a practice and become an honorary medical staff member at a public teaching hospital. Few women took up this challenge; they commonly deferred to the career of their male partner, who, if a medical specialist, travelled and worked constantly to obtain his credentials (Bollen and Saltman 2000, p. 3).

Following World War II specialists thrived with the establishment of their Colleges, hospitals and diagnostic facilities together with their developing academic standards and a solid research base. GPs generally worked from their homes, sometimes in substandard conditions, and were increasingly excluded from providing hospital services except for cottage hospitals. This narrowed their opportunity to undertake hospital procedural work and to maintain acceptable standards of medical service delivery (Bollen and Saltman 2000, p. 4).

As early as 1952, the President of the British Medical Association expressed growing concern regarding the status of the GP, saying "It is common belief that the status of the GP has become lowered...second to none in the profession" (Power and Aloizos 2000, p. 158). Demands for specialist registration to define the scope of specialist practice and General Practice was finally resolved in Australia in 1971 by the introduction of differential medical benefits under the National Health Act.

### 2.1.3 The Establishment of Medicare, a Government Subsidy for Medical Practice

In 1972 the Australian Labor Party was elected to government, the first Commonwealth Labor Government for 23 years. One of its major proposals was the establishment of a system of universal health insurance funded by means of a taxation surcharge coupled with a matching Commonwealth contribution. Legislation was passed in 1973 and a Health Insurance Commission (HIC) was established in 1974. In 1975 Medibank, was launched and managed by the HIC. A key factor in Medibank was that medical benefits covering consultations, investigations and procedures paid 85% of a set scheduled fee. The Government encouraged doctors to bill Medicare directly and accept the benefit as full payment for their service. This was called bulk billing. Doctors were not obliged to limit their payment to the scheduled fee but the patient was responsible for any additional payment, thus continuing the traditional fee for service payment system (Bollen and Saltman 2000, pp. 9-10). Over the years Medibank underwent many changes and subsequently became Medicare, that has remained Australia's national health care funding system

since 1983 (General Practice Strategy Review Group 1998, p. 234).

For GPs who were employees in General Practice and who were paid a percentage of the scheduled fee for each medical service rendered, bulk billing significantly reduced their take-home pay, given that the percentage they received was based on a discounted bulk billed fee. Disadvantaged patients with social or mental health related problems were frequently bulk billed as this prevented the practice being left with a debt.

The Health Insurance Act 1973 restricted access to Medicare benefits for medical practitioners who did not hold a postgraduate qualification under the Act. Medicare provider numbers were allocated to medical practitioners to enable them to participate in the Medicare program and to identify the place from which services are provided (Commonwealth of Australia 2005, p. 597). Those GPs who were eligible for a Medicare provider number (which allowed their patients to claim Medicare benefits or have their medical services bulk billed) have to be recognised as a GP for the purpose of the Act on, or after, November 1996.

A "recognised general practitioner" is a term used to encompass all categories of GPs who are eligible to be included on the vocational register by the HIC (Royal Australian College of General Practitioners 2004, p. 10). These doctors include both recognised GPs and persons undertaking approved placement e.g. registrars enrolled in a General Practice training program and undergoing training in accredited General Practice posts.

Recognised GPs include those holding the Fellowship of the Royal Australian College of General Practitioners (FRACGP) and those admitted to the vocational register (prior to 1995) during the "grandfathering" phase of vocational registration (VR). VR is explained elsewhere in this Chapter. Other Medical Practitioners (OMPs) could only bulk bill the HIC at significantly lower rates (Health Insurance Commission 2004a, p. 1). WGPs who were not "grandfathered" into VR or did not hold a FRACGP fell into the OMPs category, which further disadvantaged their income. Their standing as GPs in the profession was reduced, as was their capacity to become an employee of a practice, because the practice received a reduced percentage of the set schedule Medicare fee for the work of OMPs compared with recognised GPs.

Many WGPs may not have been eligible to obtain recognition as GPs because if they had been working part-time in General Practice they would not meet the "time in General Practice" requirement of five years. The 1995 Act demanded of junior doctors the commitment to a medical discipline at an early stage if their career. Some WGPs did not embrace this urgency to make a career commitment, preferring to establish their families first. GP registrars now appear to be delaying their families until their late 20s and 30s because of the requirement for early commitment to their specialty, including General Practice (*pers. comm.* Dr Frank Meumann, General Practice Training Tasmania).

Since November 1993 rural OMPs have been able to access the same Medicare 'General Practitioner Attendance Items' as recognised GPs. To retain access to the

General Practitioner Attendance Items the RACGP's minimum requirements for participation in Quality Assurance (QA) and Professional Development (PD) must be met (Health Insurance Commission 2004a, p. 1). This arrangement for rural OMPs was introduced to reward those doctors who received their medical training in overseas countries and who came to work in rural and remote locations under special arrangements with the Commonwealth Government.

### 2.1.4 Quality Assurance and Professional Development

In 1987 the RACGP introduced a QA and Continuing Medical Education (CME) program for its members. The aim of the program was to assist GPs in Australia to improve and maintain the quality of care they give to patients and to guarantee the highest possible standards of care to the community. This program would demonstrate GPs participation in effective and efficient quality assurance, and ensure the accountability of GPs to the community. It would also enhance the professional responsibility of individual GPs and Australian General Practice to reach acknowledged world standards for quality management of patients (RACGP Online 2004, pp. 1-3).

The program was expanded in 1989 when participatiou in QA and CME became one of the formal requirements for recognitiun as a GP. It continues as a formal requirement for all recognised GPs, both those on the Vocational Register and RACGP Fellows. In 1993 a point system was introduced whereby a participant GP was required to attain a minimum number of points each triennium by taking part in

accredited educational activities and PD (Royal Australian College of General Practitioners 2004, p. 8).

GPs who work part-time, are nearing retirement, or undertaking occasional locums, are required to achieve the same number of points as those GPs working full-time, the RACGP arguing that this will ensure skill and knowledge are maintained (Royal Australian College of General Practitioners 2004, p. 11). Effective continuing PD is described by the RACGP as resulting in "behaviour change" with subsequent improved clinical practice (Royal Australian College of General Practitioners 2004, p. 9). Achieving the required number of points for QA and PD can be difficult for GPs especially for those who have family responsibilities, because programs that provide QA points are frequently run in the evenings or on the weekends. These QA, CME and PD activities also add to personal expense. WGPs who provide the major responsibility for the care of their children often work part-time and have limited income and therefore find this added expense onerous.

Over the years, GPs have witnessed an increasing commitment to achieve points. In the 2005-2007 triennium two different activities are required to be completed from a proscribed category of which provides a number of options, some of which cannot be easily attained for GPs employed on a part-time basis. The options include clinical audit modules, active learning modules, small group learning, supervised clinical attachment, research, completion of a relevant higher education course, achieving the FRACGP or Graduate Diploma in Rural General Practice, or publishing an article in

a peer reviewed journal (Royal Australian College of General Practitioners 2004, p. 14).

Since January 2003, participants in ACRRM's Professional Development Program (PDP) can undertake their continuing QA and PD through ACRRM. This followed the RACGP agreeing to recognise ACRRM'S PDP as an appropriate process for maintaining recognition as a general practitioner. ACRRM's PDP is closely integrated with that College's curriculum and assessment program for vocational training and offers performance-oriented assessment modules for procedural aspects of rural General Practice (Hays et al. 2005, p. 296). Rural GPs now have a greater choice and flexibility as to how they undertake their QA and PD requirements.

### 2.1.5 Vocational Registration

In 1988 the RACGP and Department of Community Service and Health entered into discussion on setting up a system of VR for GPs. The goal of VR (introduced in 1989) was to raise the standards of care in General Practice. VR established General Practice as distinct discipline within medicine as well as a specialty in its own right and removed the capacity for doctors to become a GP without specific training and a minimum level of experience.

The basic strategies for VR included:

- Registration of GPs for Medicare purposes separately from OMPs.

- Provision of higher Medicare benefits for services provided by vocationally recognised GPs.
- Restriction of registration to GPs with formal qualifications.
- Mandatory ongoing participation in QA and CME to maintain registration (Commonwealth Department of Health and Family Services 1996, pp. 177-178).

The Medicare fee differential for non-vocationally registered GPs compared with vocationally registered GPs has remained lower for many years. For those doctors who did not already have five years of General Practice experience the requirements for VR were completion of a formal GP training program, attainment of the FRACGP by examination, ongoing CME and QA activities and agreement to participate in peer review through an independent peer review organisation (Bollen and Saltman 2000, pp. 14-15).

Attaining VR proved to be difficult for those GPs who had not attained five years in General Practice at the time of its introduction. To move out of the OMPs category some GPs who were working part-time faced several years of part-time training in the General Practice Training Program (most ultimately achieving success in the FRACGP examination). The requirements for achieving VR apparently demonstrated little understanding of the trauma this could cause for GPs and their families. It also caused hardship for WGPs who were not working in General Practice at the time of the introduction of VR. When these WGPs attempted to resume their careers in General Practice they found themselves without recognition as a GP and therefore were confined to the lower rebate. Hence these doctors found

themselves competing with junior hospital doctors for the limited number of GP training positions. This coincided with major restrictions being imposed on the number of doctors allowed to enrol in General Practice training.

### 2.1.6 Strategic Directions in the 1990s

In 1992 a historic agreement between the AMA, the RACGP and the Commonwealth Government established the General Practice Strategy. Topics to be addressed under this strategy included:

- Workforce initiatives to address oversupply and maldistribution of doctors.
- Support and recognition of postgraduate training for General Practice.
- Establishment of local Divisions of General Practice.
- Development of an independent voluntary system of accreditation for General Practice.
- Remuneration strategies to more appropriately reward GPs and to enhance the role of GPs beyond individual patient care, including a review of the Medicare Benefits Schedule.

Significant initiatives of note that arose from this Strategy included the introduction of blended payments, the establishment of Divisions of General Practice and the formation of the Rural Incentives Program which facilitated the recruitment and relocation of GPs to rural areas. A further initiative, the Better Practice Program, (BPP) (Section 2.1.4.4 of this Chapter) was not introduced until 1994 (Power and Aloizos 2000, p. 161).

In 1997 a review of the 1992 GP Strategy was commissioned by the Commonwealth Minister of Health and Family Services to identify achievements and areas for improvements in General Practice and provide advice on future directions. In particular the review was charged with considering the future of the BPP and suggesting an appropriate consultative structure. There were 16 members of the review group that included six WGPs. This review acknowledged the prevailing low morale of GPs and their feelings of isolation within the health system. There also appeared to be a lack of information transfer and loss of trust in the federal government. A more sophisticated and collaborative approach to improving General Practice was advocated to "manage the tension about...time pressures, ownership and control" (Power and Aloizos 2000, p. 161).

The report of the review *General Practice Changing The Future Through Partnerships* was released in 1998. Issues identified warranting immediate attention included replacing the BPP with the Practice Incentives Program (PIP) in order to recognise the participation of practices in the accreditation process, taking account of rural practice, the contribution of teaching practices, providing after-hours care, and achieving the targets set for immunisations. The report also recommended the development and support of information technology, increasing the opportunity for GP training, VR and CME. In addition it sought to promote new practice organisational efficiency and provide a better lifestyle and career choice for GPs. The creation of a new partnership between the profession, consumers and government was recommended through the establishment of the General Practice Partnership Advisory Council (GPPAC) in 1998 (Power and Aloizos 2000, p. 162).

The role of GPPAC was to monitor the recommendations of the General Practice Strategy Review that included blended payments through the PIP and measures to increase the medical workforce by nearly 15% (Commonwealth of Australia 2005, p. 595). GPPAC was dissolved in 2004 by the Federal Minister for Health and replaced by the General Practice Reference Group (composed of the AMA, RACGP, RDAA and ADGP). This remains the key body negotiating with the Australian Commonwealth Government at a high level (Weller and Dunbar 2005, p. 5).

Although a "better lifestyle" for GPs was among the issues contained in the General Practice Strategy Review, there was limited examination of the lives of WGPs, or consideration given to improving their lifestyle. The report acknowledged that between 1994 and 2025 the number of female practitioners will increase by 135% and the number of male practitioners by 37% (General Practice Strategy Review Group 1998, p. 97). It also suggested that, "programs may be required to induce attitudinal change in the medical profession and wider community, with the aim of increasing job satisfaction for female GPs" (General Practice Strategy Review Group 1998, p. 123). The report made brief reference to issues that have a particular impact for WGPs:

- Career pressures that encourage women to delay child bearing and rearing.
- Time away from work for WGPs may mean that they do not achieve their full-professional potential and take advantage of the career opportunities that are available to their male counterparts.
- Part-time work (more frequently conducted by WGPs) is perceived as less

valuable than full-time work.

- Lack of flexible child-care required to meet practice needs.
- Lack of parental leave arrangements.
- WGPs' clinical work consists of fewer patient encounters, greater number of long consultations and more clinical problems in a single encounter when compared with that of their male colleagues (General Practice Strategy Review Group 1998, p. 96).

### 2.1.7 Blended Payments, the Better Practice Program and the Practice Incentives Program

The introduction of the 1992 General Practice Strategy brought significant changes in financing for General Practice by introducing a blended payments system. This system was first launched through the BPP in 1994 and then through the PIP in 1998. The BPP provided a supplement for fee for service to those GPs who met stipulated criteria in their practices. The PIP saw the firm establishment of a blended payment system in addition to a fee for service system at a time when the government recommended schedule fees had fallen considerably behind the costs of running a general practice.

The BPP made payments to general practices under the Program if the practice applied and satisfied eligibility criteria relating to the General Practice being in good standing in the community (including 90% of services being provided by a recognised GP), and using Medicare recognised GP items. The practice also had to provide a comprehensive range of services including away-from-surgery visits and

patient access to 24-hour care. It had to be patient-focussed with on average 10-minute consultations (General Practice Strategy Review Group 1998, p. 263). The value of payments was based on a formula devised by the Commonwealth Department of Health and Family Services and it was paid directly to the practice. Practices in rural and remote areas qualified for a rural loading (Commonwealth Department of Health and Family Services 1996, pp. 165-166). The BPP was not popular with GPs, and provided major problems for WGPs who were not recognised GPs, or who did not provide home visits or after hours care to patients.

Activities deemed eligible for incentive payments under the PIP (1999-2000) included information technology, after-hours care, rurality, teaching medical students, and targeted programs such as immunisation or quality prescribing. A rural loading was paid to rural and remote practices. Essentially the PIP was about making payments to practices for specific services or meeting targets set by government. The practice had to fulfill a range of criteria to access PIP payments including providing primary, continuing, comprehensive care to patients as well as 24-hour care to patients and visits to the patient's home, nursing homes or hospitals. Patient feedback was required together with a flexible appointment system and a practice information sheet. All GPs taking part in the PIP had to be participating in QA and CME (Power and Aloizos 2000, pp. 165-166).

The practice may spend the PIP money as it wishes. While the government encourages equitable distribution amongst all doctors working at a practice, it claims that it cannot be responsible for individual practices' business arrangements (Health

Insurance Commission 2004b, pp. 1-2). The practice receives the payments and the employees (primarily WGPs) who work sessions may not receive any direct benefit or monetary reward.

In 1999 the Medical Benefit items for health assessments, care planning and case conferencing were introduced. These benefits have since extended to asthma, pap smears, immunisation, diabetes and mental health. In contemporary General Practice, as well as the fee-for-service payments and the PIP, there are Service Incentive payments (SIPs) for certain services in areas of e.g. mental health and vaccination (Van Weel and Del Mar 2004, p. 89). The incentive-specific areas from 2004 include information management and technology, after-hours care, teaching medical students, quality prescribing, employing practice nurses, chronic disease management and rural practices (Richardson et al. 2005, p. 78). Employed GPs (many of whom are women) may receive some financial reward through the SIPs but the problem of the practice being paid directly under the PIP remains.

### 2.1.8 Accreditation of General Practices

In 1991 the RACGP, with the support of the AMA and the Commonwealth Government, resolved to develop a set of national standards for General Practice with the aim of engaging the profession in a comprehensive process of continuous quality improvement.

In 1992 the three bodies released a discussion paper entitled *The Future of General*

*Practice: a strategy of the nineties and beyond.* It proposed "an independent and voluntary system of practice accreditation be developed to enhance the delivery of services and facilities to general practices through a process of continuing quality improvement" (RACGP Online 2004, p. 1).

Responsibility for developing methods and proposals for accreditation was initially handled by an Interim Steering Group on Accreditation with a membership representing the AMA, RACGP and Commonwealth Government. During 1994-1996 the RACGP conducted a Presidential Taskforce on Standards and Accreditation with wide representation from the medical profession, consumers and Department of Health and Family services. The taskforce set essential criteria for the establishment of an independent accreditation organisation; it should not be for profit and should be controlled by the profession. it should be open and accountable to government and the community, it should offer accreditation on an equitable basis to all practices across Australia, and it should use a peer review process involving at least one GP representative (RACGP Online 2004, p. 1).

In 1997 Australian General Practice Accreditation Ltd (AGPAL) was incorporated and the Articles of Association were last updated in 2004. AGPAL is a member-based and member-lead not-for-profits company that is governed by a Memorandum of Understanding dated 1997. The prime function of AGPAL was to develop, manage and administer a system of accreditation and to accredit practices by the application of standards developed by the profession (Marisa Vecchio, *pers. comm.* AGPAL).

The founding membership of AGPAL board comprised representatives of the AMA, the AMA Council of General Practice, the RACGP, (plus the RACGP Censor in Chief), the Australian Association of General Practice (AAGP), the RDAA and the ADGP Board (plus an ADGP member). On the board (but not members) were representatives of the Department of Health and Ageing and of the Consumers Health Forum of Australia (CHF). At the AGM in December 2003 representation of the Minister of Health and Family Services was discontinued. Membership was expanded in 1999 to embrace the Australian College of Rural and Remote Medicine, the National Association of Medical Deputising Australia and the Australian Association of Practice Managers. Representatives of these organisations have never appointed directors to the board.

The AGPAL Board of Directors currently consists of one director each from the AMA, the AMA Council of General Practice, the RACGP, the RACGP Censor in Chief, the RDAA, the AAGP and the CHF. In addition the ADGP now has one Director's position for a member of an Urban Division of General Practice and one Director's position for a member of a Rural Division of General Practice (*pers. comm.* Marisa Vecchio, AGPAL).

Draft Entry Standards for General Practice were released by the RACGP in 1993 and in 1996 Entry Standards for General Practices (RACGP 1996) were circulated to all GPs. The second edition of Standards for General Practice was released in 2000 (General Practice Strategy Review Group 1998, pp. 210-211), with a third edition released in 2005.

The process of accreditation involves interviewing the principal GP and staff, observing the practice operation and facilities, and reviewing medical records, patient feedback, practice data and documents, appointment schedules, policy and procedure manual and HIC data (RACGP Online 2004, p. 2). Accreditation involves a three-year program during which practices perform self-assessment against the RACGP Standards for General Practice. Practices also undergo a survey visit by their peers, commence a continuous quality assessment for best practice and receive documentary validation and recognition as an accredited General Practice on achievement of AGPAL Accreditation (Australian General Practice Accreditation Limited 2004, p. 1). Accreditation must be undertaken by all practices wishing to access the PIP.

Practice Accreditation and the PIP have added an additional layer of administration to practice management. A practice involved in the cycle of accreditation and the ongoing process of meeting the standards requires considerable energy-input of practice staff and GPs. The financial cost associated with meeting the standards and remaining accredited is also considerable. This challenge and commitment to administer this process may discourage some GPs (particularly part-time WGPs) from owning and running general practices. As employees the WGPs are relieved of this responsibility. Regardless of the benefits that accreditation provide, it is founded on a model of regulation and bureaucratic administration that intrudes into the operation of the practice and furnishes practice managers with newfound power and domination.

### 2.1.9 Organisations and Colleges Concerned with General Practice

The organisations considered in this Chapter are those that impacted upon the professional and non-professional lives of the research participants. Prior to the 1990's the organisations representing the interests of general practitioners were the AMA (through the National Association of General Practitioners of Australia, a GP interest group working within the AMA) and the RACGP. Numerous changes have since taken place in General Practice, including a proliferation of organisations claiming to represent GP interests.

In 1961 the AMA formally became an autonomous body, inheriting the existing structure, machinery and personnel of the branches of the British Medical Association (formed in 1855) that had been established in all the Australian States between 1897 and 1911 (Gardner 1995, p. 345). The British College of General Practitioners was formed in 1952 and in 1953 a faculty of the British College of General Practitioners was formed in New South Wales (only six month after the first faculty had been established in Britain). In 1958 the Australian College of General Practitioners was incorporated and in 1969 the College was granted the right to use the prefix Royal and hence the RACGP. This provided "the attainment of a position of rapport with other Royal Colleges" (Winton 1983, p. 76).

By the early 1990s the RDAA, the AMA Council of General Practice, the AAGP and the regional Divisions of General Practice were established. At the present time the AMA, RACGP, RDAA and Australian Divisions of General Practice (ADGP) are the

major players in Australian General Practice. These organisations have had representation on the General Practice Financing Group and General Practice Advisory Group to the Federal Minister for Health and Aged Care (Rudd and Steed 2000, p. 200).

#### 2.1.9.1 The Australian Medical Association

The AMA is responsible for the political and industrial issues of members. It is an independent organisation which represents more than 27 000 GP and other specialist members and has primary responsibility for advancing the professional interests of doctors and the health of the community (Australian Medical Association 2004, p. 1). It has a federal structure in Canberra, with State and Territory branches.

At the time this research was conducted the AMA's Council of General Practice provided advice and support to GP members and advocated for rural doctors. The AMA represents GP members by developing and implementing policy on the main issues impacting on General Practice in collaboration with the AMA networks, the profession and key stakeholders. The focus is on defending the professional independence of GPs by improving their remuneration, working conditions and professional work environment (Australian Medical Association 2004, p. 1).

The AMA promotes ethical behaviour, high clinical standards, independence of the doctor-patient relationship, public health, academic medicine, professional and economic independence, doctors' well-being and the political, legal and industrial

interests of doctors. It also embraces professional communication and cooperation both within the profession and between the profession and the community.

### 2.1.9.2 The Royal Australian College of General Practice

The RACGP is responsible for standards, training, education and research in General Practice It was established with the following objectives:

- To promote a scientific approach to problems of disease at the level of the individual and family.
- To promote the prevention of disease and guard the nation's health and the welfare of the community by every means available to the general practitioner.
- To foster and maintain high standards of General Practice.
- To encourage and assist young men and women in preparing for, qualifying in and establishing themselves in General Practice.
- To stimulate postgraduate education of general practitioners by providing facilities applicable to General Practice.
- To conduct clinical research into conditions most frequently seen and appropriately studied in General Practice (Winton 1983, p. 22).

The RACGP was keen to establish a training program for recent graduates prior to their entering unsupervised General Practice, and to establish a qualifying examination for GPs. The first formal qualifying examination for General Practice was held in 1968 (Bollen and Saltman 2000, p. 6). The RACGP underwent a successful accreditation process by the Australian Medical Council (AMC) in 2003 as part of a quality assurance program for all specialist Colleges. As a result of this

process the RACGP is now endorsed by the AMC as a specialty College (Hays et al. 2005, p. 291).

#### 2.1.9.3 The Rural Doctors Association of Australia and The Rural Doctors Associations (RDA)

In 1988 the potential power of rural doctors working together was clearly illustrated by the New South Wales (NSW) doctors' dispute regarding the Commonwealth Government's removal of an after-hours loading. This led to the establishment of the Rural Doctors Association (NSW) and later to the Rural Doctors Association of Australia in 1991 at the first national rural health conference held at Toowoomba, Queensland (Humphreys et al. 2002, p. 3). The RDAA is an incorporated association of each State plus the Northern Territory and gives rural doctors a national voice and a focus for the consideration of national issues.

The Rural Doctors Associations are autonomous entities, which negotiate with government and other bodies in their own jurisdiction. Members are typically drawn from small rural towns and remote areas in category 4 to7 of the Rural, Remote and Metropolitau Area Classification System (RRMA). This classification system is described later in this Chapter (Rural Doctors Association of Australia 2004, p. 1).

The vision of the RDAA is "excellent medical care in Australia's rural and remote communities and to advocate for highly skilled and motivated medical practitioners who are adequately trained, remunerated and supported, both professionally and

socially" (Rural Doctors Association of Australia 2004, p. 1). The RDAA developed considerable political expertise and recognised that it had members who were well trained GPs in rural and remote communities. It also provides support, policy development, research, submissions, and strategic advice on relevant rural issues. The RDAA was responsible for the formation of ACRRM in 1997 (Rudd and Steed 2000, p. 217). The educational issues concerning rural and remote GPs were passed to ACRRM, the RDAA's academic arm.

#### 2.1.9.4 The Australian College of Rural and Remote Medicine

ACRRM was established as a professional organisation for rural medical training in Australia. Its core function was to determine and uphold the standards that define and govern competent unsupervised rural and remote medical practice (Australian College of Rural and Remote Medicine 2004. p. 1). Its broader goals were to design and administer a dedicated vocational training program with appropriate certification for rural doctors, coordinate contiouiog medical education for rural GPs, and develop a re-certification process (Rudd and Steed 2000, p. 217). The Women in Rural Practice was a foundation committee with the intended role of ensuring appropriate representation of female doctors in ACRRM activities. ACRRM has included consideration of issues for female and male doctors in its prospectus, its criteria for Fellowship, and as a core unit in its Primary Curriculum (Wainer 2001, p. 2).

### 2.1.9.5 Rural and Urban Divisions of General Practice and the Australian Divisions of General Practice

The formation of Divisions of General Practice was proposed in the 1992 General Practice Strategy and by 1993 there were 100 rural or urban Divisions established. Divisions of General Practice are local networks of GPs, funded by the Department of Health and Aging. Divisions aim to improve health outcomes for patients by encouraging GPs to work with other health professionals by improving that quality of health service delivery at the local level (Modra et al. 2003, p. 1). Divisions embrace population health, service to GPs, service by GPs to patients, and allied health under the More Allied Health Service and Workforce Support for Rural GPs' Programs. Divisions pay GPs for the activities they perform on behalf of the Division (Modra et al. 2003, p. 1).

The 2000-2002 Annual Survey of General Practice Divisions showed that Divisions had grown to organisation-status with more than 1 100 full-time equivalent staff, 120 Divisions and a membership of approximately 95% of the 21 958 GPs practicing in 2001-20002 (Modra et al. 2003, p. 1). State-Based Organisations (SBOs) have since been established to facilitate the interconnectivity between Australian Divisions of General Practice and rural and urban Divisions (Rudd and Steed 2000, p. 211).

Over the years there have been a number of structural and financial changes to Divisions. To support maturing Divisions SBO, Rural Workforce Agencies (RWAs) and a national Divisional representative body, namely the ADGP were formed. The

divisional agenda has included workforce issues, financial arrangements for GPs, practice management, GP morale and well-being. Divisions have also been involved in quality of care, coordination of health services, chronic illness, financing arrangements for incentive payments, quality use of medicines and access to GP service and after-hours medical care. In addition it covers information management, technology, and accreditation of practice trials in population health issues concerned with mental health, youth health, asthma, diabetes, cervical screening and immunisation. The divisions are also key providers of education and training activities to GPs (Modra et al. 2003, p. 2).

The Australian Divisions of General Practice were established in 1998 with a primary objective of promoting the health and well-being of Australians thorough Divisions of General Practice (Australian Divisions of General Practice 2004, p. 1). Other objectives of the ADGP are strengthening the effectiveness and vitality of the General Practice sector through support to member divisions and SBOs, advocacy and representation of divisional members to the Federal Government, to other organisations and to the Australian Public. The ADGP also contributes to the national health policy, promotes cooperation and communication with other national organisations in Australia and provides national leadership in the health system (Australian Divisions of General Practice 2004, p. 1).

#### 2.1.9.6 Australian Association of General Practice

The AAGP was established in the early 1990s as an independent political

organisation of GPs aiming to represent medico-political interests for General Practice. While it is independent of the RACGP and AMA, many of the founding members were AMA or RACGP members. The AAGP is recognised by government as an important advisory group, and is represented on the General Practice Partnership Advisory Council (Rudd and Steed 2000, p. 216). The association had around 700 members at its peak but membership fell to 200-300 by 2003 (Ferguson 2004, p.1).

#### 2.1.9.7 Australian Federation of Medical Women and the Medical Women's International Association (MWIA)

The AFMW was established by medical women, for medical women, to give them voice at national level and the State and Territory levels through the Medical Women's Society. It seeks to promote the interests of Australian medical women in areas relating to their professional lives and to act and represent medical women in all matters of mutual interest at the national and international level. In particular it is concerned with the further education of Australian medical women (Medical Women's International Association 2004, p. 1). This organisation is committed to improving the health and welfare of all people, but especially women and children in the Australian community. In the Medical Women's Societies of the Australian States and Territories medical women who are registered as medical practitioners or eligible for medical registration are entitled to membership (Rudd and Steed 2000, p. 216).

The AFMW has links with the Medical Women's International Association founded in 1919, and has a membership crossing 75 countries and five continents. All medical women, qualified according to the accepted standard of the medical profession in their own country, are eligible for membership. The association is represented in the World Health Organisation (WHO), the Economic and Social Council of the United Nations and the United Nations Children's Fund (UNICEF). The MWIA established official relations with the Board of the General Council of International Organisation of Medical Sciences and has non-government organisation official observer status to the World Medical Association (Medical Women's International Association 2004, p. 1).

### 2.1.9.8 Australian Association of Academic General Practice (AAAGP)

The AAAGP "has been in existence for 20 years as an association of people who are undertaking research that will add to the body of knowledge of the discipline of General Practice, or are teaching and thereby refining and propagating this body of knowledge" (Heard 2000, p. 1). It represents the voice of academic departments of General Practice and other institutions and individuals working to increase the knowledge base of the Discipline of General Practice. The aims of the organisation are to support General Practice at the national level, to set Priorities in General Practice research in cooperation with consumers and Health Departments, and to advocate for suitable funding models and processes (Heard 2000, p. 9).

The AAAGP encourages teaching and research, provides a forum for the exchange of

information and ideas and fosters the career development of academics of General Practice. Academic staff of recognised institutions involved in General Practice and other teachers and researchers in the field of General Practice are eligible for membership (Rudd and Steed 2000, p. 216). The AAAGP sets national priorities, lobbies for research funding, liases with other bodies in setting national goals and targets, and disseminates research findings. Members of the organisation are linked by e-mail.

### 2.1.10 Training for General Practice, the Family Medicine Program and the RACGP Training Program

Vocational training for General Practice is one of the RACGP's key responsibilities. In 1973 (at a time of GPs shortage) the RACGP established the Family Medicine Program (FMP) that was a national GP training program. It was funded by the Commonwealth Government and aimed to encourage medical graduates to enter General Practice and to upgrade the standards of training for General Practice. It trained teachers for the program, accredited training posts in General Practice, produced educational training material and undertook appropriate research into problems of health in the community. In 1974 it commenced retraining for women and other graduates who had been away from General Practice for an extended period. This successful aspect of the program was subsequently terminated, leaving the retaining of GPs (mostly WGPs) in limbo after time-out of practice (Bollen and Saltman 2000, p. 10).

The FMP was a four-year training program established on principles of adult education with open-ended flexible "adult learning". Initially it had no formal selection, only formative assessment and no formal endpoint qualification. In time it instituted a competitive selection process, more defined stages, a written curriculum and improved linkage with the end-point examination for the FRACGP (Hays and Piterman 2000, p. 358).

In 1980-81, the FMP introduced formative and summative assessment, contract learning, mentors for subsequent General Practice experience, a computerised self-assessment system and a Certificate of Satisfactory Completion of Training (Ministerial Review of General Practice Training 1998, p. 9). In 1990 the training period was shortened to a minimum of three years and the RACGP examination for the FRACGP became the final exam of General Practice training necessary for gaining VR and recognition as a General Practitioner (Ministerial Review of General Practice Training 1998, p. 10).

The Family Medicine Program was renamed the RACGP Training Program in 1993. The Commonwealth Government introduced an "outcome schedule" for the annual grant to the Training Program, examples of outcomes included implementing a merit-based selection process, limiting the number of entrants to the program to 400 a year, recognition of prior learning and experience, developing a detailed curriculum (achieved in 1997). It also involved limiting leave and elective time, developing a system of continuous quality improvement and outcomes-evaluation plan and

integration of the program with other General Practice education and training (Ministerial Review of General Practice Training 1998, p. 10).

In response to a claim that the RACGP Training Program was producing too few GPs for rural and remote practice, the RACGP established a Faculty of Rural Medicine in 1992 to focus on education and training for rural General Practice. This Faculty was renamed the Rural Faculty in 1996. A specific rural training stream for rural General Practice was set up in the RACGP Training Program in 1993. By the mid 1990s the number of rural training stream registrars throughout Australia had increased to 294 with 202 in the four year program (Hays and Piterman 2000, p. 362). Additional requirements of the Rural Training Stream included hospital terms undertaken in regional hospitals, GP terms in rural practice (50% are mandatory), at least 12 months of training in rural practices, rural components coordinated by Rural Health Training Units in regional areas and an additional year of Advanced Rural Skills Posts. Upon satisfactory completion of rural training the registrar received the RACGP's Graduate Diploma in Rural General Practice in addition to becoming a Fellow of the RACGP following successful completion of College exam (Hays and Piterman 2000, p. 362).

Since the inception of the Rural Training Stream the RACGP found itself in continuing conflict with ACRRM, registrars having to decide whether they would join the RACGP Trainiog Program or seek ACRRM affiliated training through Rural Health Training Units (RHTU) which were established in all States and the Northern Territory. ACRRM did not have its own training program and nor was the Fellowship of the Australiau College of Rural and Remote Medicine (FACRRM) a

qualification that enabled a GP to become recognised or be entered on the vocational register (Hays and Piterman 2000, pp. 362- 363). ACRRM is currently undergoing the process required to achieve recognition as a specialist College (Hays et al. 2005, p. 291).

### 2.1.10.1 Reviews of Vocational Training for General Practice

The 1995 Holgrove report entitled *Alternative Approaches to Vocational Training for General Practice* was undertaken by UK consultants with the aim of exploring alternative approaches to vocational training for General Practice in Australia. The report recommended that there be more than one pathway for vocational training in General Practice and that a single body (a Board of Studies for General Practice Training) be responsible for all vocational training for General Practice (Ministerial Review of General Practice Training 1998, p. 11).

In 1997 the Minister for Health and Family Services announced that a Review of General Practice Training would be undertaken to consider future General Practice education and to ensure the system was capable of meeting the needs of the Australian community into the 21st Century. The Review report *General Practice Education: the way forward* was released in 1998. It identified difficulties existed in the system's ability to equip doctors with the necessary skills for rural practice, that more women and mature aged students were entering medicine, and that more GPs were working part-time. Of considerable concern was the lack of continuity of General Practice education. The review group consisted of 14 GPs including five

female GP members and a female medical student (Ministerial Review of General Practice Training 1998, p. vii).

The report stated that there was a need for a greater diversity in work settings and learning environments, a broader culture within medical practice and education, recognition of prior learning, increased flexibility for learners and a community focus at all levels of medical education. The report also recommended the establishment of a National Council for General Practice Education and Training, the development of local consortia and the development of teaching practices and more funding to support community-based education (Ministerial Review of General Practice Training 1998, p. viii-ix).

The report noted that female WGPs remained under-represented in rural General Practice and that the annual number of new rural female GPs did not reflect the number of female graduates. It was also observed that WGPs chose to work in larger communities (Ministerial Review of General Practice Training 1998, p. 27). ACRRM believed that the training of females for rural practice was critical considering the increasing numbers of females entering medicine and General Practice, and that rural training of WGPs required the involvement of female mentors (Ministerial Review of General Practice Training 1998, p. 44). The report recommended support for female doctors to teach in medical education programs, and that the content of the curriculum be addressed for intending WGPs (Ministerial Review of General Practice Training 1998, p.70).

Responsibility for some of the difficulties with education, training and service delivery was clearly placed on WGPs, their increasing numbers being seen as a problem. While emphasising that it was essential that WGPs be given an increased exposure to rural and remote General Practice both during training and in the workplace, the report did not consider the implications of this for WGPs and their families, or how this would impact upon their professional and non-professional lives.

The National Council for General Practice Education existed from1998 to 2000 and was responsible for the development of a coherent General Practice education system. This Council was intended to support the central role of vocational training in General Practice education and had a direct reporting relationship to the Minister (Ministerial Review of General Practice Training 1998, pp. 60-62).

Strasser (cited by Britt, 2001) reported that State and Commonwealth Governments have delivered an extensive range of incentives and programs to improve recruitment and retention rates of rural and remote health care providers, especially GPs. There has been an improved access to continuing medical education and an increase in the number of female practitioners in rural areas. However because of the aging rural GP population and a decrease in the length of stay for GPs in a rural area, these changes appear to have resulted in a static rural workforce (Britt et al. 2001, p. 3).

### 2.1.10.2 General Practice Education and Training (GPET) from 2001-2005

In 2001 the Federal Government ceased providing financial support for the RACGP Training Program and established and funded a regional and contestable system of General Practice vocational training across Australia. These changes consisted of GP training based on the regionalisation of training delivery and the tendering out of GP training to regional consortia. Regional training providers in rural and urban areas accommodated both the Rural Pathway and General Pathway of the training program, with the first intake of registrars in 2001. Training of pre-2002 GP registrars was provided by General Practice Education Australia (GPEA), a company of the RACGP. However from 2004 this training was also managed by GPET.

GPEA conducted a three-year full-time vocational training program including one year in hospitals and six-month terms in basic General Practice (six months of the total can be approved special skills positions). The rural training stream required more extensive exposure to rural General Practice involving up to a year of advanced training skills. A policy of Recognition of Prior Learning enabled eligible GP registrars to reduce the length of their enrolment in training by up to one year (Medical Training Review Panel 2003, pp. 74-75).

GPET contracts consortia to provide General Practice vocational training and in 2003 there were 22 training consortia. Entry to GP training is competitive and the program is for three years full-time. Part-time General Practice registrars must work at least three sessions a week in General Practice. Rural Pathway registrars are required to

undertake the majority of their training (a minimum of 18 months) in rural and remote areas (RAMA 4 to 7 as defined by the Rural and Remote Metropolitan Area Classification). One purpose of this pathway was to encourage younger GPs to practice in rural and remote areas and help to address the maldistribution of GPs in rural Australia. Attainment of the FRACGP is the end-point of vocational training after which graduates are able to continue study in special interest areas, in rural skills or in academic areas. Graduates can attain postgraduate qualifications in rural General Practice (Graduate Diploma in Rural General Practice) or a Fellowship of the Rural and Remote College of General Practice (FACRRM) (Medical Training Review Panel 2003, p. 74).

#### 2.1.10.3 Academic General Practice

The Committee on Medical Schools lead by Professor Peter Karmel was established by the Commonwealth Government in 1973, and recommended among other things that "all medical students be offered an insight into general practice, to learn about important problems rarely seen in hospital practice and best taught in general practice" (Ministerial Review of General Practice Training 1998, p. 11). Medical Schools were offered funds to establish chairs and academic units of community practice. The term "community practice" was chosen because the committee did not consider General Practice to be an academic discipline, rather they saw it as part of community medicine (Ministerial Review of General Practice Training 1998, p. 11). All universities accepted the funds, with chairs being filled by professors from various backgrounds. According to Holsgrove "The new professors had a hard time.

They were beset by a lack of funds, a lack of staff and the slings, arrows and pin pricks of ambivalent established specialist staff departments" (Ministerial Review of General Practice Training 1998, p. 11).

The universities' progress on implementing the recommendations of the committee was reviewed by Professor Eric Saint in 1980, who was scathing about universities who took General Practice earmarked Commonwealth money and gave little in return. "Unfortunately Saint did not take up the cudgels over the implementation of his report, which resulted in not a single action" (Ministerial Review of General Practice Training 1998, p. 11).

In 1988 the Committee of Inquiry into Medical Education and Medical Workforce, chaired by Professor Doherty, confirmed the findings of Saint and recommended in its report that undergraduate exposure to General Practice be expanded and enhanced, including in rural areas. It also recommended that GPs be paid appropriately for teaching medical students. Again no action was taken (Ministerial Review of General Practice Training 1998, p. 11).

In 1990 Kamien and MacAdam identified that the status of academic General Practice within medical schools was in a weak state, with few staff holding only a small fraction of the medical curriculum and few graduate research students. The teaching of students in general practices relied on the goodwill of GPs to provide teaching and often accommodation, this usually free of charge. Very few GPs had attained a doctoral research degree and in all Australia there were only 20 GP

academics at the level of senior lecturer or above (Hays and Piterman 2000, p. 351).

Several factors have contributed to the improvements in General Practice training since that time, particularly the criticism by the AMC of some medical schools that provided less than four weeks General Practice in their medical courses, the 1993 Commonwealth's General Practice Rural Incentives Program (known as the RUSC Program) which tied rural experience and curriculum contents to its funding and accountability requirements, and the General Practice Evaluation Program Grants (founded in 1991) which provided competitive grants for research into General Practice (Ministerial Review of General Practice Training 1998, p. 12). As a result most medical schools have since secured teaching time and increased staffing levels to facilitate the teaching of generalist skills. Rural undergraduate support grants are now available to increase exposure to rural health and rural practice in undergraduate medical courses and graduate medical programs have been introduced, at Flinders University in 1996 and at the Universities of Sydney and Queensland in 1997.

The Commonwealth Government introduced the Primary Health Care Research Evaluation and Development Program (PHCRED) in 2000. This provided funding for University Departments of General Practice and Rural Health to develop the capacity of the primary health care sector to conduct research and implement research findings in clinical practice. The guiding principle was to engage in strategic partnerships with medical and non-medical groups, including Divisions of General Practice, academic departments, primary health care organisations and consumer groups. This collaboration was designed to facilitate research, evaluation and

development programs that were unlikely to be obtained in isolation. A further aim was to produce knowledge that would contribute to the development of an evidence base for primary health care and increase the pool of researchers in General Practice and Primary Health care.

The Commonwealth Government commenced a funding program to establish ten University Departments of Rural Health (UDRH) in 1996 (Humphreys et al. 2000, p. 120). The role of the UDPRH was to contribute to an increase in the rural and remote health workforce through education and training programs in rural health for undergraduate medical, nursing and allied health students. It supported health professionals practicing in rural settings and aimed to reduce the health differentials between rural and urban people and between indigenous and non-indigenous peoples. The organisational arrangements of the UDRH varies widely, as does the mix of programs and activities in education, research, service development, facilitation and advocacy.

The Federal Budget of 2001 provided funding to nine universities with medical schools to set up new clinical schools in rural Australia, aiming to attract medical graduates back to rural areas. The Rural Clinical School funding provided resources for students to study in rural areas for substantial periods during the clinical years of their medical undergraduate course. Currently ten rural clinical schools form a network across Australia and it was anticipated that from the beginning of 2004 academic year, at least 25 per cent of medical students would receive a minimum of 50% of their clinical training in rural and remote areas.

Other new medical schools have recently been established in the Australian National University (ACT), Bond and Griffiths Universities (Queensland) and Notre Dame University (Western Australia). These schools will allow an increase in the number of medical students, including international medical students (Hays et al. 2005, pp. 286-287).

# Section 2

## 2.2 Literature Review of the Demographics of Women General Practitioners in Australia

### 2.2.1 Introduction

According to Britt, *et al.* (2003) General Practice is the point of entry for most patients into the Australian health care system and the GP holds the gatekeeper-role for their entry into the secondary and tertiary sectors of this system. About 85% of the 19.7 million Australians attended a GP at least once during the year 2002 (Britt et al. 2003, p. 1). There are more than 17 000 recognised GPs in Australia and about 1 500 registrars enrolled in a General Practice training program, equivalent to one GP per 90 persons. GPs provide most of the (approximately) 100 million non-specialist services each year to the population that were paid by Medicare, at an average annual rate of 5.2 services per person (Britt et al. 2003, p. 1).

### 2.2.2 Australian Medical Workforce Reviews

The demography of WGPs in Australia is necessarily provided against the backdrop of the GP workforce in this country. The 1973 Karmel report *Expansion of Medical Education* noted that the number of GPs in Australia had just kept pace with population numbers, that the average GP's workload had increased over that of previous years, and that a significant increase in doctor numbers would be required relative to population over the next 20 years. These findings resulted in the implementation of policies for major increases in medical student numbers (Australian Medical Workforce Advisory Committee 2000, p. 21).

The Sax report of 1980, *Medical Manpower Supply* revised estimates of population growth downwards, noting that net medical migration was occurring at levels substantially above those projected in the Karmel report. As a result the projected GP workforce requirements were also revised downwards. Likewise the 1980 Jamison inquiry into the efficiency of Australian hospitals found that there was an oversupply of doctors in Australia. However in attempting to assess this argument, the commission was confronted with poor data (Australian Medical Workforce Advisory Committee 2000, p. 21).

The Doherty report *Australian Medical Education and Workforce Into the 21st Century* (1988) noted the widespread impression in the medical profession of an over-supply of GPs in urban areas. It suggested that there was an increasing demand for General Practice by medical graduates and patients. Workforce planning was

based on doctor to population ratios recommended by the medical Colleges, with the RACGP recommending one GP per 1 000 population. The report noted the view of a number of the Colleges that the current doctor numbers were adequately meeting population needs for services (Australian Medical Workforce Advisory Committee 2000, pp. 21-22).

Since the mid 1990s the direction of the medical workforce policy has been aimed at improving the geographic distribution of GPs and matching key medical workforce demand with supply, a process that has been hastened by the release of the Australian Medical Workforce Advisory Committee (AMWAC) recommendations (Medical Training Review Panel 2003, p. 43). In 1996 the then Commonwealth Department of Health and Family Services produced a report *General Practice in Australia 1996* which used 1994 data to derive statistical estimates for Australian population needs for consultation, as well as estimates of the numbers of full-time equivalent (FTE) GPs needed to service these consultation workloads. These data revealed considerable maldistribution of the workforce, with an oversupply in metropolitan areas and an undersupply in rural areas.

This report also synthesised information on the history and nature of General Practice, the interaction of General Practice with other health sectors, GP education and training, and financial data. A comprehensive government review of General Practice was undertaken by the General Practice Strategy Review Group in 1998, this indicating that the rural GP shortages nation-wide could be as high as 1 000. It also claimed there was growing evidence of emerging shortages of locums in urban areas

as well as GPs for after hours work and as practice partners (Australian Medical Workforce Advisory Committee 2000, p. 22).

The history and findings of the various national reviews of medical training and the medical workforce in the last 34 years are summarised in the AMWAC discussion paper *Medical Workforce Supply and Demand in Australia* (1999). This report also examined the lifestyles, practice economics and other influences which gave rise to higher concentrations of GPs in metropolitan areas and lower concentrations in rural and remote areas. The subsequent AMWAC report *General Practice Workforce in Australia 2000* reiterated the poor geographic distribution of GPs, noting that there had been GP shortages in rural areas over the last 20 years. These various reports resulted in the implementation of policies for major increases in medical student numbers (Australian Medical Workforce Advisory Committee 2000, p. 21).

### 2.2.3 General Practice and Women General Practitioners as an Increasing Component of the Primary Care Workforce

Women are a substantial and increasing component of the GP workforce. By 1994 women accounted for 26% of medical practitioners, nearly 50% of the medical school eurolments and 45% of the first degree graduates from medical schools (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1996, p. 1). Supporting evidence of the marked increase in the proportion of female GPs is provided by their reported rise from 19.3% of the workforce in 1991 to 35.2% in 2003 (Charles et al. 2004, p. 86 ).

The AMWAC *General Practice Workforce in Australia Supply and Requirements Report* (2000) gave consideration to numbers of women in medical schools, in GP training, and in the workforce. An update of this AMWAC Report was to have taken place in 2003 but is still unavailable in the public domain. The composition of the primary care medical practitioner workforce reflects trends towards greater average age and the greater female representation. Between 1995 and 2000 the average age of primary care clinicians rose from 46 to 49 years. Of the male primary care practitioners, 33% were aged 55 years and over in the year 2000, compared with 12% female primary care practitioners in this category. Female practitioners made up more than half of those aged under 35 years in the year 2000. Retiring male practitioners will inevitably be replaced by a cohort comprising a high proportion of females (Sims and Bolton 2005, p. 104).

While women have taken an increasing burden of General Practice work, there are indications that they are leaving the workforce sooner than males. Schofield and Beard (2005) reported a 55% attrition of 'War and Depression'-born WGPs aged 60-69, compared with an attrition of 35% of males of this age group, leading to their predicting that the imminent retirement of the 'baby boomer' generation will place an unprecedented pressure on the medical workforce (Schofield and Beard 2005, pp. 80-83).

### 2.2.4 Part-Time Versus Full-Time Work by WGPs in Australia

WGPs are much more likely to practice part-time than men, and this fraction has

increased in recent years, yet the average hours worked by all doctors has remained almost unchanged from 1994 (44.9 hours/week) to 1998 (45.3 hours/week). The increase in doctors working 65 or more hours/week (from 9.6% in 1994 to 14.1% in 1998) has thus been largely balanced by those working less than 35 hours per week (reducing from 24% in 1994 to 26.6% in 1998) (Anstralian Institute of Health and Welfare 2000, p. 6).

In 1994 65.5% of the female primary care practitioners worked part-time (less than 40 hours per week) compared with 23.2% of male primary care physicians. The 1996 *Female Participation in the Australian Medical Workforce report* predicted that the average female GP would work 66.0% of the hours of an average male GP over a lifetime, this rising to 74.9% for female specialists relative to their male counterparts (Australian Institute of Health and Welfare 1999, p. 3).

In 1997 51.6% of female primary care practitioners worked fewer than 35 hours per week, compared with 12.9% of their male counterparts, while 4% of the male and 1.2% of the female primary care practitioners worked 80 or more hours per week. The proportions of both male and female practitioners working 80 or more hours per week were higher in rural and remote areas at 7.5% of males and 2.2% of females (Australian Institute of Health and Welfare 1999, p. 19).

Data collected in 1998-1999 showed female GPs aged 25-29 years worked about 40 hours per week, those aged 35-39 worked about 30 hours per week, and those aged 55-59 years worked just over 40 hours per week. The average hours worked by male

GPs was at a maximum of around 55 hours per week for the 40-44 age group and remained relatively static to the age of 50-54 before declining steadily to retirement (Australian Institute of Health and Welfare 2000, p. 7). The average number of hours worked by primary care practitioners in remote areas (51.2 hours per week in 1995 and 51.0 hours per week in 1999) was higher than the national average of 42.3 hours in 1995 and 45.3 hours in 1999 (Australian Institute of Health and Welfare 2003, p. 21).

The 2002 Australian Bureau of Statistics (ABS) study showed that 60% of female GPs worked less than 40 hours per week at the time of the census compared with 17% of male GPs. At the other end of the spectrum 37% of male GPs and 11% of female GPs worked 60 hours or more per week (Australian Bureau of Statistics 2002, p. 7). GPs in rural areas averaged 52 hours work per week and those in remote areas averaged 57 hours work per week, compared with 46 hours per week for metropolitan GPs (Australian Bureau of Statistics 2002, p. 8 ).

The report '*Evolution of the General Practice Workforce*' 1991-2003 (Charles et al. 2004, p. 87) highlighted the trend of WGPs towards shorter working hours; 24.7% working less than six sessions per week in 1999 compared with 31.1% working less than six sessions per week in 2003. The proportion of male GPs working fewer than six sessions per week also rose, from 6.1% in 1999 to 11.4% in 2003, confirming anecdotal reports that male GPs have decreased their working hours in General Practice.

### 2.2.5 WGPs in Rural or Urban General Practice

WGPs are preferring to practice in a capital city or major urban centre; in 1990-1991 32.2% of rural GPs were female, this proportion dropping to 23.4% in 2002-03 (Charles et al. 2004, p. 88). Conversely female GPs in metropolitan practice rose over this period, from 67.8% to 76.6% of the total (Charles et al. 2004, p. 88 ).

The RRMA classification system was developed in Australia in 1994 for data analysis by zones. There are two metropolitan (RRMA 1 and 2), three rural (RRMA 3, 4 and 5) and two remote (RRMA 6 and 7) zones based on population numbers and an index of remoteness (Rural Doctors Workforce Agency 2004). In 2002, 28% of the 3,855 GPs working in RRMA areas 4 to 7 were female (Doyle 2003, p. 9). By 1994 83% of female primary care practitioners were in urban areas (compared with 77% of male counterparts), against 17% of female primary care practitioners located in rural or remote areas (compared with 23% of male counterparts) (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1996, p. 2). By 1997 however the proportion of WGPs in urban areas had dropped to 80.6%, with a concomitant rise in the female rural medical workforce to 24% (Australian Institute of Health and Welfare 1999, pp. 18-46).

In 1998 15.6% of all medical practitioners worked in rural areas (23.6% of them female), serving 28.7% of the Australian population (Australian Institute of Health and Welfare 2000, p. 3). Of the females, 69.5% were involved in primary health care and 10.8% were specialists. At the time of the ABS 2002 report, 82% of all GPs

worked in metropolitan areas, 16% of all GPs worked in rural areas and 1% worked in remote areas (Australian Bureau of Statistics 2002, p. 4). The distribution of GPs by State and territory was similar to that of the Australian population. On average there were 0.96 GPs for every 1 000 people, based on the estimated resident population in December 2001(Australian Bureau of Statistics 2002, p. 7).

### 2.2.6 WGP Work Patterns and Patient Characteristics

An Australian Morbidity and Treatment Survey (Brit *et al.* 1996) found that the 20.9% of female primary care practitioners recorded less than 60 patient encounters per week, against 5.2% of male practitioners in this category. Conversely 5.5% of females and 22% of males recorded 161 to 200 encounters per week. Female primary care practitioners reported more problems per encounter and fewer encounters involving only one problem. They also had fewer home visits than male practitioners and their consultations were twice as frequently billed as long consultations. Just over 70% of encounters of female practitioners were with female patients, compared with 55% of encounters of male practitioners with female patients. Even after controlling for the difference in patient mix, female primary care practitioners managed more female-specific, endocrine and psychosocial problems than their male counterparts (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1996, p. 2).

The ABS study of 2002 found that 22% of WGPs reported 150 or more private patient contacts per average week against 56% of male GPs (Australian Bureau of

Statistics 2002, p. 7). There is also an increasing reliance on older male GPs to care for the increasing numbers of high-care dependent residents in age-care facilities, while WGPs undertake more practice-based consultations involving the clinical management of acute conditions and younger patients (Lewis and Pegram 2002, pp. 84-86). Likewise procedural work in rural and remote areas is undertaken mostly by older, male GPs who work long hours and are approaching retirement (Sims and Bolton 2005, pp. 105-106).

Rural and remote GPs in Australia mostly work in group practices or other community-based types of practice, the Aboriginal Community Controlled Health Organisation (ACCHO) being the only one having equivalent numbers of male and female doctors. In all others there are more males than females. Fewest female GPs are found in solo rural and remote practiees. Most of the fee-for-service GPs are male, while most of those on private practice or ACCHO salaries are female (Doyle 2003, p. 10 ).

Britt, *et al.* (2002) showed that the average consultation by WGPs lasted 15.9 minutes, compared with 14.3 minutes for male GPs. Consultations by young female GPs (aged less than 45 years) lasted 16.0 minutes, compared with 13. 4 minutes by their male counterparts. Male GPs aged under 45 years in metropolitan settings had the shortest consultations (13.3 minutes) and rural female GPs aged 55 years or more had the longest (16.7 minutes) (Britt et al. 2002, pp. 876-879).

Britt *et al.* (2004) reported that a higher proportion of female patients have longer

consultations, and female patients most often see WGPs. Female patients also had a higher rate of psychosocial and genital problems. Consultations lasting longer than 20 minutes were inevitably more complex, this being related to the number and types of problems, chronic problems, psychosocial and gynecological problems, provision of advice and counselling and ordering of pathology tests (Britt et al. 2004, p. 103).

A 2004 report of recipients of the FRACGP showed that they were more likely to be female, relatively young, of Australian nationality and working fewer sessions in larger practices. Their consultations were longer than average, they prescribed fewer medicines, they handled more clinical treatments and procedures and ordered more pathology tests (Miller et al. 2004, p. 770).

### 2.2.7 Age Distribution of GPs

The primary care practitioner workforce in Australia has aged, increasiug from 45.8 in 1995 to 47.7 years in 1999 (Australian Institute of Health and Welfare 2003, p. 19), while over the same interval the proportion of primary care practitioners aged 55 and over grew from 22.5% to 25.1%. The effect of the numerically dominant 'baby boomer' generation is seen in a comparison of the age distribution of GPs in Australia in 1986 and in 2001, with a clear shift towards the higher end of the range (Schofield and Beard 2005, pp. 80-84). It is auticipated that the impeuding retirement of this group will have a major negative impact on the GP workforce.

The primary care practitioners working in remote areas in 1999 were younger than

their colleagues in other geographic areas (42.3 years compared to the national average of 47.7 years). Possibly this was because younger practitioners with few family commitments were drawn to remote locations to gain experience before settling down in areas with better access to services. Just over 45% of the female primary care practitioners working in remote areas were under 35 years, compared with 20% being under 35 in capital cities (Australian Institute of Health and Welfare 2003, p. 20).

The ABS report of 2002 showed that 10% of Australian GPs were aged less than 35 years, 62% were aged between 35 and 54, 19% were aged between 55-64 and 10% were aged 65 and over. The sex distribution of GPs was 67% male and 33% female. Female GPs had a younger age profile than male GPs with 55% of female GPs aged less than 45 years and 15% aged 55 years or over. This compared with 31% of male GPs being aged less than 45 years and 35% being over 55 years (Australian Bureau of Statistics 2002, p. 6 ). WGPs in rural and remote areas were also younger than male counterparts, 65% being under the age of 45, compared with 43% of male doctors in this category (Doyle 2003, p. 9).

### 2.2.8 Work Setting in General Practice

The majority (86.6%) of Australian GPs worked in their private rooms in 1998. Of the female GPs, 7.5% worked in solo practices compared with 17.9% of male GPs and 61.6% of female GPs were employed in practices of four or more people compared with 55.3% of male GPs. There was a 10.1% increase in the number of

practices of five practitioners or more between 1997 and 1998 (Australian Medical Workforce Advisory Committee 2000, p. 6).

Between 1999 and 2003 GPs of both sexes tended to move into larger practices. Of the female GPs, 9.6% were in solo practice in 1999 reducing to 6.9% in 2003. The number of GPs of both sexes in two- to three-GP practices fell significantly between 1999-2003, by 2.7% of the total for males and by 3.9% of the total for females. Not surprisingly, the proportion of both male and female GPs rose in practices with four or more practitioners over this period, by 4.9% and 0.6% respectively (Charles et al. 2004, p. 88).

### 2.2.9 Special Interest Practice

In 1994, 7.5% of male and 10.9% of female primary care practitioners were reported as working in a special interest areas such as Women's and Children's Health (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1996, p. 54). Special interest fields of practice were diverse, with the most popular in 1997 being women's health and counselling/psychotherapy (Australian Institute of Health and Welfare 1999, p. 19). There was a decline in special interest practice from 8% of the primary care workforce in 1998 to 7% in 2000. However primary care practitioners report that their practice in areas of women's health has risen by 40% over this period (Commonwealth of Australia 2004, p. 106).

### 2.2.10 Registrars in Training for General Practice

In 1994 12.7% of female medical practitioners and 4% of male practitioners were registrars training for General Practice, with females constituting 59.1% of registrars in General Practice (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1996, p. 56). The proportion of female registrars in General Practice had risen to 60.4% in 1997, with these registrars comprising 5.3% of the primary care practitioner workforce (Australian Institute of Health and Welfare 1999, p.18).

The average age of a GP registrar in 1997 was 32.8 years for males and 31.6 years for females (Australian Institute of Health and Welfare 1999, p. 20). Male registrars worked on average 46.4 hours per week against 35.6 hours per week for female registrars. Of the female registrars, 40.4% worked fewer than 35 hours per week (compared with 11.5% of males). 74.4% of them (and 68.9% of the males) were located in metropolitan practice, 23.1% of them (and 28.7% of the males) were rural, while 2.5% of them (and 2.4% of the males) were located in remote practices (Australian Institute of Health and Welfare 1999, p. 20).

In 1998 females made up 57.8% of GP registrars (Australian Institute of Health and Welfare 2000, p. 6) and in 2000 comprised 60.8% of the registrars in the RACGP General Practice Training Program (Australian Medical Workforce Advisory Committee 2000, p. 6). The AMWAC report *The General Practice Workforce in Australia 1999-2010* states that 32.1% of the year-2000 registrars were located in

rural or remote areas (Australian Medical Workforce Advisory Committee 2000, p. 7 ).

The Medical Training Review Panel of 2003 reports the number of registrars enrolled in General Practice Training in 2003 as 1 446, amounting to 23.6% of all vocational trainees in Australia (Medical Training Review Panel 2003, p. 1). A total of 953 training positions for vocational trainees in all disciplines were available in rural/remote areas, constituting 15.6% of the 2003 training positions, a low percentage when compared with the 28.7% of Australian population in rural/remote areas. Of the rural training places, 38% were in General Practice (Medical Training Review Panel 2003, p. 1). There has been a 28.7% increase in total rural/remote recognised vocational training positions from 2001-2003 (Medical Training Review Panel 2003, p. 38 ).

The percentage of female GP Registrars in General Practice rose from 56.6% in 1997 to 60.5% in 2003 (Medical Training Review Panel 2003, p. 40), at which time 46.5% of all vocational trainees and 60.5% of General Practice Registrars were female (Medical Training Review Panel 2003, p. 23 ). From 1997 to 2003 there has been a 9.8% decrease in numbers of registrars in General Practice, against a 50% increase of first year training places over this period. The cause of this decrease in registrars was the capping of entry to the GP Training Program at 400 new places per year from 1997 to 1999, the cap being raised to 450 from 2000 to 2002 (Medical Training Review Panel 2003, p. 32).

A total of 918 graduates were in General Practice education and training in 2003, with 600 first-year General Practice places likely to be available in 2004 (Medical Training Review Panel 2003, p. 10). A total of 1 446 GP registrars were in the program in 2003, 73 of whom were training part-time (Medical Training Review Panel 2003, pp. 1-55). Since 2001 GP Training Program places have been held at 600 annually but these have not always been filled (Charles et al. 2004, p. 89).

In 2004, 1 623 registrars were in the General Practice Training Program, with 56% of the 526 entering the program that year being female. In the same year 47% of the 188 registrars entering rural training for General Practice were female, giving a total of 613 registrars in rural training (compared with 968 in urban training) in 2004. Of the total number of GPs in rural training in 2004, 48% were female (*pers. comm.* Anne Messenger, General Practice Education and Training).

A total of 567 applicants were processed in the first (May 2004) General Practice Training intake for 2005, compared with 616 applicants for the first (May 2003) intake for 2004. This reduction in numbers was mainly attributable to a large number of applicants (100) in the second selection process in November and December 2003 following the years of capped medical school places. Applications for 2005 have shown a significant redistribution relative to 2005 from 57% to 50% away from the major metropolitan regions of Sydney, Melbourne and Brisbane. Australian-born applicants increased from 33% to 44% of all applicants while the percentage of Australian-trained applicants rose from 63.6% to 64.9% between 2004-2005 (Coote and Messenger 2004, p. 1).

### 2.2.11 Fellowship of The Royal Australian College of General Practitioners

In 2002 new Fellows in General Practice comprised 44.5% of all new Fellows admitted by Medical colleges (Medical Training Review Panel 2003, p. 3 ). Of the new Fellows in General Practice, women comprised 59.2% of the total in 2000, 56.8% in 2001 and 47.9% in 2002 (Medical Training Review Panel 2003, pp. 50-51 ). Between 1991 and 2003 the proportion of females with the FRACGP increased by 31.3% (to 44.3%). This compared with an increase of males with the FRACGP by 12.2% (to 32.2%) over the same period (Charles et al. 2004, p. 89).

### 2.2.12 Medical Students

A 1996 AMWAC report on the *Medical Workforce in Rural and Remote Australia* showed that against a backdrop of increased medical-student enrolments, the proportion of female students from rural areas had fallen between 1989 and 1995 by 12.3% (Australian Medical Workforce Advisory Committee 1996, pp. 19-20).

Data collated in 1994 showed that women comprised nearly 50% of medical school enrolments (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1996, p. 9). The proportion of commencing female medical students rose from 46% in 1997 (Australian Medical Workforce Advisory Committee (AMWAC) 1998, p. 3) to 50.3% in 1998, marking the first time that females commencing medicine exceeded 50% of the intake (Australian Institute of Health and Welfare 1999, p. 65).

In every year since 1998 over half of the Australian students commencing in all ten medical schools in Australia were female (Australian Institute of Health and Welfare 2004, p. 4-6). The average age of students commencing a medical degree rose from 18.9 years in 1991 to 20.6 years in 2000. In 1990, 43.6% of undergraduate medical students and 41.3% of postgraduates were female, this proportion growing to 48.0% and 54.4% respectively by 1999 (Australian Institute of Health and Welfare 2003, p. 30).

One third of Australian medical school places are now graduate entry programs, with a corresponding increase in older medical students. The number of international fee-paying students commencing medical degrees in Australian universities has rapidly increased, with approximately 20% of all undergraduates being of overseas origin in 2002. A significant number of these students are remaining in the Australian medical workforce after graduation, a trend assisted by recent changes to regulations (Joyce et al. 2004, p. 6). In 2004 the government introduced 246 new medical school places and the opening of new medical schools are expected to add more places into medical undergraduate training (Coote and Messenger 2004, p.1).

### 2.2.13 Country of Graduation

One of the most significant changes in the medical graduate workforce has been the drop in the proportion of Australian graduates from 81.4% in 1991 to 72.2% in 2003 (Charles et al. 2004, p. 87). The proportion of female GPs graduating in Australia in

1991 was 80.5%, this proportion dropping to 75.2% in 2003. In the case of female GPs, 9.9% graduated in Asia in 1991 and 9.0% in 2003. Male GPs were less likely to have graduated in Australia in 2003 (70.6%) than in 1991 (81.7%), and were more likely to have graduated in Asia in 2003 (10.2 %) than in 1991 (4.8%). There was a significant rise in the proportion of African graduates from 2.8% (2.2% female, 0.6% male) in 1991 to 8.7% (4.7% female) in 2003 (Charles et al. 2004, p. 88).

### 2.2.14 Overseas Trained and Temporary Resident Doctors

According to Charles *et al.* (2004) overseas trained doctors holding visas for up to five years conditional on their rural placement have been recruited at the rate of about 200 per year since 2000. Temporary resident doctors (with a visa stay of up to two years) were estimated to make up 4.6% of the rural workforce in 1997 and data from 2000 shows an increase about 50 of these doctors per year since 1997. More recently temporary resident doctors have been offered four-year visas and overseas trained doctors have visas for up to ten years, with the possibility of gaining Australian qualifications and permanent residence (Charles et al. 2004, p. 89).

### 2.2.15 General Practice Activity in the States and Territories of Australia

The report *General Practice Activity in the States and Territories of Australia 1998-2003* provides for the first time a comprehensive comparative analysis of General Practice activity in all States and Territories, based on the *Bettering the Evaluation and Care of Health* (BEACH) data from 1998 to 2003. The BEACH report shows

that at the time the data was collected, WGPs comprised 32.6% of the total GP workforce, and the majority of patients visiting their doctors were female (59.1%) (Britt et al. 2004, p. 77).

Current data shows that approximately 34% of primary medical care practitioners are female. This proportion generally holds across the major Australian States, the exceptions being Tasmania (29%), the Australian Capital Territory (47%) and the Northern Territory (51%). A generally older primary care workforce in Tasmania and a generally younger workforce in the Northern Territory provides some explanation for the discrepancies in these regions. Why the Australian Capital Territory has a higher proportion of female primary care practitioners is not clear (Sims and Bolton 2005, p. 112).

### 2.2.16 Limitations of Published Demographic Data

Medical workforce data in Australia provides a mix of information that is often confusing and difficult to interpret, this having a flow-on effect on workforce planning or the planning of General Practice services. Sometimes assumptions have been made on the future activity of GPs and the General Practice workplace in the absence of data analysis. When these prove to be incorrect, more recent data is by then outdated, especially since a lag of up to two years may occur between data collection and publication. This is exemplified by the 1998 AMWAC report *Influences of Participation in the Medical Workforce* (AMWAC 1998, pp. 1-85), a retrospective study involving medical practitioners who graduated between 1967 and

1992. Although the conclusions were of interest, they related to events at least six years earlier, and to an older group of GPs whose activity and lifestyle may not have represented those of a younger generation.

Although information on the medical workforce became more readily available from 1994, the use of different terminologies (often with different meanings in different reports) abounded, including e.g. clinicians, primary care practitioners, GPs, specialists, vocationally registered primary care practitioners, other medical practitioners, medical workforce, female/male practitioners, rural medical practitioners, and remote GPs. This multiplicity of terminology possibly embracing different subject-groups, adds to the difficulty of interpreting data trends. Hayes (2002) described medical-workforce research as follows:

> An interesting, yet risky academic business, based on many complex issues relating to definitions, data sources, and the measurement and interpretation of doctor population ratios…[I am] inclined to think that GPs have a better sense of what is happening on the ground that do the sifters of data. It is not necessarily the total number of GPs that is changing but rather their work patterns and the biggest challenge to workforce analysis, and therefore to patient access to GP care, may be the societal changes in work patterns, not [the] raw numbers (Hays 2002, p. 92).

Joyce *et al.* (2004) reported that although Australia had been in the forefront of developing medical workforce planning, the evolution of methods used were not

keeping pace with system-wide developments and emerging issues. The major changes taking place that determine medical workforce supply such as the increasing number of women in medicine, changing lifestyle expectations and globalisation, were being monitored but other crucial factors were not. These included trends in the profile of Australian medical graduates (graduate entry programs and international fee-paying students), availability of face-to-face clinical time versus non-clinical work such as research and teaching, attrition from the medical workforce, supply and demand for other health professionals (nurses, allied health professionals and "alternative" medicine providers) and re-skilling of medical practitioners for changed roles. These authors recommended that medical workforce planning needed effective monitoring of all key factors affecting supply and demand, a systems-level perspective and a dynamic approach. They noted that significant gaps existed in Australian data and there was a failure to incorporate all relevant data into modeling, as well as a total lack of longitudinal data (Joyce et al. 2004, pp. 343-344).

Joyce *et al.* (2004) identified that the "big picture" perspective of the total Australian medical workforce is missing and at a broad level there is fragmentation and narrowness of scope in the existing reports dealing with particular disciplines within the medical workforce. There are also "political" influences on workforce planning and uncertainties in forecasting future workforce requirements. The future requires key players to be incorporated into a system-level integrated planning approach that considers a full range of dynamic variables and accounts for their inherent uncertainty and complex interactions (Joyce et al. 2004, p. 345).

These issues need to be understood and addressed if progress is to be made with workforce data and planning for the future needs in General Practice. This thesis argues that two key factors presently missing in workforce planning are consideration of the whole-person concept of the life of a GP and the balance between his or her professional and non-professional life. By not identifying and incorporating these factors in demographic studies the outcome of workforce planning is piece-meal, and could lead to incorrect conclusions, flawed modelliug and policy decisions that have serious ramifications for both GPs and patients. In this thesis the components of the mosaic that forms the professional and non-professional lives of WGPs will be identified, and the difficulties in balancing these components will be highlighted. The conclusions reached may contribute to improved modelling and planning for General Practice.

# Section 3

## 2.3 Review of the Literature Regarding Medical Women in Australia (1972-2004)

### 2.3.1 Introduction

Research reports regarding women in medicine in Australia were scarce prior to Fett's survey of Australian medical graduates in 1972. At that time women made up 19.1% of all medical graduates in Australia and 30.5% of new enrolments in 1973. The participation of women graduates in both medical and non-medical work was increasing and Fett predicted that by the end of that decade one third of all medical graduates were likely to be women (Fett 1974, p. 697).

Fett's work showed the trends in medical practice from 1920 to 1969, the distribution in occupational areas, and the sex differentials in medical practice. Trends were also evident from individual to group practice, from longer to shorter hours of medical work, from non-salaried to salaried forms of practice, and from medical to non-medical work (Fett 1974, p. 697). These changes are ongoing as reported in this Chapter.

### 2.3.2 Marriage, Parenthood and Gender Roles

Fett studied the effect of marriage and parenthood on the professional practice of graduates of both sexes. Although both sexes have identical training and graduated on equal terms after the first intern year, discontinuities relating to gender identity were seen in the professional lives of the women but not of men. Fett claimed that feminine gender identity in conventional terms has to do with "being receptive, passive, nurturing and supportive" (Fett 1974, p. 696). However, masculinity

> ...includes the notion of aggressiveness, dominance and achievement, qualities which are validated and reinforced and are profitable in the hierarchical and authoritarian structures of medical schools and hospitals (Fett 1974, p. 695).

A further exploration of the different characteristics of women and men will form part of this thesis.

Fett reported that marriage and parenthood supported the professional work of men but formed discontinuities for women. As their children increased in independence, the working hours of medical women increased, in contrast to a corresponding decrease for medical males (Fett 1974, p. 696). Most husbands of medical women asserted that they were in favour of their medical wife continuing to work, but only if it did not "interfere with family life". The hours that medical wives worked were a measure of the "threat levels" to domestic tranquillity and stability of marriage and the professional lives of women were consequently impaired, while for men this

impairment did not exist.

Fett noted that the WGP-wife filled in for her medical husband when he was ill, under pressure, or away on holiday. She also attended patients whom "he feels his wife may be better able to deal with", answered the telephone when he was out on call and did night work when he was tired. In short the medical wife made an "unquantifiable contribution to their husband's careers that is nnacknowledged professionally or financially" (Fett 1974, p. 696).

A major disadvantage for medical women is that they lack the invaluable assistance of 'wives'. How WGPs cope without the assistance of 'wives' and how they fill the roles of wives and medical practitioners will be investigated in this thesis. As Fett claimed:

> Doctors wives, even those with substantial help, who are [a] minority, also run the house, bring up the children, and provide their husbands with physical and emotional care. This is true also for wives working full-time. Male doctors have wives to give them these necessary supports for the arduous practice of medicine, but no one give them to a woman doctor...and women doctors do not have any functional equivalent of a tax-deductible dependent wife (Fett 1974, p. 697).

For working medical mothers child-minding centres and domestic help are a necessary component of their work and medical women consider that they should be tax deductible. The continued absence of such relief in many situation at the present

time, tends to reflect acceptance of the historical structure of medical education and practice that has been "designed by and for male practitioners who...assume the priority of professional over domestic life" (Fett 1974, p. 697).

### 2.3.3 Domestic Work and Children in the Household

As well as supplying medical services, medical women have frequently also borne responsibility for domestic and child-care work and a common way of achieving these multiple roles is to work in medicine part-time. In addition to practicing, medical women have been found to perform almost as much domestic work as did the wives of their male colleagues:

> The sex-linking of household work is clear. Women doctors do not, because they are doctors, relinquish this domestic load, but, because they are women, carry almost as much as the women married to their male colleagues and who are mostly full-time housewives (Fett 1976, p.34).

Women doctors often found their only way to alleviate their domestic labour was to employ home help and this cost was not tax deductible. Conversely male practitioners could frequently claim wives (undertaking the same domestic work and child-rearing tasks) as dependants for tax purposes.

The number of hours worked by medical women was shown in Fett's work to be linked to the number of children in the family. Women with no children worked

longer hours even than those who were not married. Increasing the number of children in the family not only created more domestic chores but the number of individuals that must be cared for and supported was increased:

> The presence of one child is associated with movement [of the mother] into lower hours of medical work, and a second does not affect this pattern very much more. A third child, however, does affect it...[and] there is marked further movement of women doctors into shorter hours of medical work (Fett 1976, p. 35).

In contrast Fett showed that increasing the number of pre-school children was associated with increasing hours of medical work for males, as few men participated in the care of their children. As Harris *et al.* report, domestic issues for women doctors, especially those with children remain a critical determining factor in the choice of specialty for Australian medical graduates in 2005 (Harris et al. 2005, p. 295).

### 2.3.4 The Triple Challenge

The triple challenge that women face in their careers and the demands placed on them by the conflicting needs of their children, partner and career has been described by Davidson (1978) as an example of "role strain" (Davidson 1978, p. 903). Dennerstein *et al.* (1989) noted that nearly all male doctors surveyed expected their wives to take care of the children, and females aged 40-60 had a higher involvement

in household activities and child-care, the peak income years for male medical graduates. Unless restructuring and flexibility was introduced into career training and work patterns, the career potential of women doctors with a husband and family was never reached and this was to the disadvantage of the community (Dennerstein et al. 1989, p. 390 ).

A recurring theme in the literature reviewed in this thesis was the need for change to better accommodate medical women during their training and professional work. Successive generations of medical women have struggled with the same barriers, but the profession and society have been slow to institute changes in order to relieve the burden that many medical women bear while making a contribution to medicine.

### 2.3.5 Medical Women as Second Class Citizens

Fett (1976) demonstrated that the more qualified women graduates were, the more likely they were to continue to practice. However,

> ...while the profession complains that women under-use their medical education...it virtually ensures they will under-use it by making discriminatory regulations (Fett 1976, p. 38).

Fett reported that women frequently gravitated toward positions that were considered as the lower ranks by working in preventive medicine, General Practice, public health and family planning. They also worked in the Red Cross Blood Transfusion Service,

Mother and Child welfare service and provided sex-education to school children. Fett's survey showed that there were no men working in spastic centres, in maternal and child welfare, or in marriage guidance and counselling. Rather, men worked in hospitals, university administration and as medical officers in schools, industries and universities. In these positions they had greater influence or authority over future members of the medical profession. Men effectively controlled policy-making and legislation for the medical profession. The 1974 annual report of the AMA showed an absence of women in policy making, but affirmed that it was

> ...firmly convinced that...the views of all professionally active women should be heard and made known through organizations that are adequate for their needs (Fett 1976, p. 38).

These men had clear views on what was constituted "adequate needs" for professionally "active" women and they would allow these "professionally active" women to at least express their views. Those women who were professionally "inactive" had no voice, and were invisible. Taking on the role of wife and mother signalled the end of a woman's professional life and her opinions no longer counted.

WGPs are often isolated during their early years of parenthood both professionally and in their personal lives and this eliminates their opportunity to learn the political and managerial skills needed to acquire and retain positions of power and authority. As Fett concluded, if amendments to the postgraduate training procedures are not made and a more equitable distribution of domestic labour is not found, a second-

class status is likely for women in medicine, to the detriment of both the profession and the community (Fett 1976, p. 34). Why some women consider that they are second-class in their professional and non-professional is a question for consideration in this thesis.

### 2.3.6 Do Women Waste their Medical Training?

Fett (1974) discussed the proposal of restricting female entry to medicine on the grounds that medical training is expensive and women "waste" it. In Fett's opinion men also "waste" their training and were doing so increasingly, while the level of participation of women was rising. She proposed that women should be able to avoid leaving the medical workforce during their parental years. To facilitate this the rigidity of the postgraduate training system should be replaced by the provision of a system more compatible with care of pre-school children and half-time residency training (Fett 1974, p. 694).

A survey of 60 students who graduated from the University of Queensland in 1958, fifteen years after their graduation, showed 60% were in private practice and 40% were in full-time salaried jobs. Of the ten women, seven were still in substantially "full time jobs" (Battersby 1975, p. 315). Despite the lack of evidence of different performances of the ten women graduates relative to the men, Battersby considered that these results combined with those of Fett (1974) (showing that 24% of medical women either temporarily or permanently retired between 11 and 15 years after graduation) indicated a waste of medical training. He further claimed that if there

was not to be a "gross wastage of medical manpower…training programs particularly for postgraduate qualifications need urgent restructuring". The existence of disadvantage for medical women in training programs and what needs to be done to rectify this situation are issues that this thesis will address.

Gill (1975) also concluded that women leaving the workforce or working part-time contributed to the "decreasing productivity of Australian medical manpower" (Gill 1975, p. 563). He thought that training male doctors provided more certainty regarding productivity and "manpower", whereas women may take time out to care for a homes and family and "waste" their medical training and the large cost invested by society in training them. Apparently Gill casts medical women into a second-class category since it is their lot to care for the household, thereby wasting their expensive education and potential. Conversely Gill holds the conviction that male doctors are the pillars of productivity in the medical profession and clearly are not called on to undertake lesser duties of caring for a family.

### 2.3.7 When Women Occupy a Minority Group

In 1987 the University of Melbourne Medical School celebrated its 125th anniversary and the centenary of women in the school. Whitworth (1987) noted that although the University of Melbourne intake of female students into medicine was 46% in 1987 and the honour-boards were "sprinkled" with their names, things had not changed all that much during the 100 years (Whitworth 1987, p. 549). An exception was Priscilla Kincaid Smith who held a personal chair in the Department of Medicine (1975 to

1991) and was the first medical woman professor in the Medical School. More women were entering physician training but few women applied for College grants and there were not many women on Council or its committees. In considering why this inequity was so, Whitworth concluded that men must join women in sharing the work of a home and family:

> Most women (and men) choose to marry, and most women (and men) choose to have families...Allowing some part-time training is welcome, but the fundamental problems of the demands of training remain. Unless, or until husbands and wives and mothers and fathers take an equal share in management of home and family, women are likely to remain a minority group in internal medicine (Whitworth 1987, p. 549).

In a 1987 study of the medical graduates of the University of Melbourne Dennerstein *et al.* (1989) reported that female doctors' professional careers were more "circumscribed" than those of their male counterparts and considerable gender differences were evident in professional achievements, income levels and professional lifestyles. Women were less often involved with teaching, lecturing, committees of medical organisations, medical administration, research or publication, they being mostly found in clinical practice (Dennerstein et al. 1989, pp. 389-390). This echoed Fett's view that female doctors tended to occupy second-class professional lifestyles with poor prospects for promotion.

### 2.3.8 Womens' Incomes and Hours Worked

Dennerstein *et al.* (1989) reported that female doctors earned significantly less than male doctors, were more likely to be employed as locums or to work in sessional employment or community health centres, and fewer of them specialised (Dennerstein et al. 1989, p. 390). These findings were reflected in two earlier surveys (Rowe and Carson 1983, pp. 45-49; Rowe et al. 1986, pp. 1145-1148) that highlighted the tendency of WGPs to work part-time in research, health centres, mental health and government employment. However, General Practice was the largest growth area for female WGPs.

In contrast to other reports cited above, Dennerstein *et al.* found that very few women gave up medical practice since 95% of those medical women aged less than 60 had remained in active medical practice compared with 97.5% of male doctors. Female doctors worked fewer hours than male doctors but their mean workload of 36.0 hours a week would be considered by the community to be equivalent to full-time employment. By comparison male doctors worked a mean of 52 hours per week (Dennerstein et al. 1989, p. 387).

Dennerstein *et al.* found that women doctors earned 58% of the mean annual income earned by male doctors. The income for female doctors was largely independent of the number of hours worked, with the mean annual income of females who worked 60 hours or more per week amounted to 65.5% of their male counterparts in the same category (Dennerstein et al. 1989, pp. 387-388 ).

Although female doctors tend to be the employees of men, they are less likely to achieve senior positions or take part in the broader range of professional activities. The explanation by one establishment for the under-achievement of female doctors was that "Women do not actually aspire to prestigious posts in medicine but are, by nature, content to fulfil their biological roles of wife and/or mother" (Dennerstein et al. 1989, p. 390 ).

As Harris *et al.* (2005) showed, reasonable hours of work, flexible working arrangements, conducive working conditions and a female-friendly work culture were important factors that influenced the choice of specialty for Australian medical graduates (Harris et al. 2005, p. 295). This thesis reviews the trend for WGPs to be employees, to work part-time and to seek flexibility to cater for their roles as doctors and family carers.

### 2.3.9 Balance and Generational Difference

Young (2004) maintained that most GPs: "...cannot do the same task for 30 years no matter how rewarding it is", rather they need to experience diversity in their interests in their lives, both medical and non-medical (Young 2004, p. 101). This concept is in contrast to the past behaviour of GPs who were often on call 24 hours a day for most of their working lives. As Young said:

> The [balancing] act needs to be individualised, fine tuned to different phases of our lives...We must be constantly reflective,

> seek diversity, prioritise the demands and not be afraid to change directions...The profession should embrace the diversity of roles (Young 2004, p. 102).

Tolhurst and Stewart (2004) claimed that balance was an important component of work, family life, lifestyle, career decisions, work strnctures and location, social life and leisure pursuits (Tolhurst and Stewart 2004, p. 363). These authors also found generational change in attitude to work and life which was contributed to by an increase in dual-career families, the changing role of men in families and the increasing age of medical graduates (Tolhurst and Stewart 2004, p. 363). Sewell also noted that both women and men are demanding change in organisations and in their work places to allow for a more balanced lifestyle (Sewell 2001, p. 376). Exploring the extent of generational change and the priorities of jnnior male and female GPs is clearly a core issues in this thesis.

### 2.3.10 The Way Women Work

Britt (1996) found significant differences in the work patterns and patient-mix of male and female GPs, WGPs managing more female-specific, endocrine and psychosocial problems and longer and more in-depth consultations (Britt et al. 1996, p. 403). Britt's study raises questions of how the practice styles of women differ from those of men and whether the consumer values the women's style of medical practice. Data from the Australian Longitudinal Study of Women's Health showed that female patients value the opportunity to see a woman doctor and that young

women are significantly more likely than middle aged or older women to see a female doctor:

> It is the culture of practice exhibited by female doctors that young women find attractive, rather than an essential appeal of the gender of the practitioner (Bryson and Warner-Smith 1998, p. 144).

Bryson and Warner-Smith (1998) draw attention to the "notable difference in the communication patterns and interpersonal skills of male and female doctors", claiming that this characteristic is consistent with research that shows "that women patients find women doctors easier to talk to and [also] feel more comfortable and less embarrassed with them" (Bryson and Warner-Smith 1998, pp. 144-147).

International studies confirm that medical women have an approach to practice that is different and appealing to patients, especially female patients. This approach places a woman's medical career as part of her life but not the exclusive focus of it. De Koninck *et al.* (1997) showed that women have their "own way" of "being a physician" that reflects "the interconnection between their private and professional lives as well as the reproduction of gender relations in their private sphere" (De Koninck et al. 1997, p. 1831). Being a physician is a part of an "evolution in gender relations" even though the "strategies adopted by women to carve out a sphere for themselves prove to be essentially individual" (De Koninck et al. 1997, p. 1831). Bertakis *et al.* (1995) maintained that women have a different style of engagement with patients:

> Compared to male physicians, female physicians engage in more positive talk, partnership-building, question-asking, and information-giving. These practice-style differences may also explain the apparent link between physician gender and patient satisfaction (Bertakis et al. 1995, p. 407).

Physician gender also has an influence on preventative services to women patients, the patients of women physicians being more likely to have received a pap smear or blood cholesterol test within the last 3 years (Cassard et al. 1997, p. 199). A Dutch study showed that female GPs spent more time with their patients and have a stronger tendency to provide continuity of care and these factors improved the satisfaction of the patients (Bensing et al. 1993, p. 219). Female primary care physicians have also been shown to engage in more communication that could be considered patient-centered and gave longer visits than their male colleagues (Roter et al. 2002, p. 756). Notably, West (1984) reported that "an extensive body of research indicates that men interrupt women much more often than the reverse, across a variety of situations. Some conclude that men's interruptions of women in cross-sex conversations constitute an exercise of power and dominance over their conversational partners" (West 1984, p. 87).

It appears that WGPs have a style of service provision that is characteristic and different from that given by male counterparts. Bryson and Warner-Smith (1998) claimed that rural women living in Australia were more likely to suffer from psychosocial problems than men, and female GPs dealt with more women's presentations of these problems than their male colleagues. The WGPs also dealt

with a greater number of problems per visit and provided more counselling. This "characterises the culture of female practice" (Bryson and Warner-Smith 1998, p. 148). This thesis will address the different styles that WGPs display in the professional workplace in order to explain how WGPs prefer to work in General Practice.

### 2.3.11 Medical Women Working in Politics, Leadership and Decision Making

Australian medical organisations concerned with General Practice first opted to elect women as their national Presidents or Chairpersons in 1998. However, as Quadrio (1991) stated, women in leadership positions are in a "double bind":

> If they ignore women's issues they may be accused of being identified with a patriarchal organisation, while if they advocate on behalf of women they are likely to be accused of chauvinism (Quadrio 1991, p. 100).

Quadrio maintained that the presence of women in the politics is still a problem. Fett (1976) and Dennerstein (1988) previously noted that women were generally excluded from positions of authority and policy making in medicine. Fett further claimed that women also occupy a "second-class status" in professional bodies organised by men. A professional woman may be the only woman in a group, especially in male-dominated areas of seniority. She may have been selected as a "token woman" and this may increase her feelings of isolation and alienation and affect her mental health and well-being (Quadrio 1991, p. 101).

Gordon (1980) reported that the kind of discrimination that persists in medicine is not only of a gross variety but a subtler nature based on the micro-inequities of daily life, advocating open recognition and condemnation of discriminatory behavior, and suggesting the establishment of groups where female students and graduates can deal with these problems (Gordon 1980, p. 360 ). These suggestions of open disclosure of discrimination and its condemnation may be easier to achieve in theory than in practice and the fear of reprisal by the perpetrators is often sufficient to silence the victims. More information about how WGPs are involved in politics, leadership and decision making will be discovered in this thesis as the existing socio-political space that WGPs occupy in organisations is explored.

### 2.3.12 Strategies for Supporting WGPs Working in Rural Practice

As indicated in the introduction of this thesis, a number of studies have been undertaken regarding rural WGPs. Reviewing these studies provides background information that will assist in the exploration of issues concerning rural WGPs in this thesis.

In 2000 the New South Wales Rural Doctors Network surveyed all rural and remote WGPs and specialists against a matched cohort of male GPs in New South Wales. The survey showed that WGPs required additional initiatives to those required by male GPs to address issues of recruitment and retention in rural practice. The males "tended not to mention family responsibilities" whereas the females were "very

concerned about difficulties related to balancing professional and family responsibilities" (McEwin 2001, p. 4). The introduction of "family friendly" rural medical workforce initiatives was recommended.

Other recommendations from this survey addressed the major themes that came from the WGPs' responses, these being balancing work and family life, flexible practice and training opportunities, establishing support networks to overcome social and professional isolation and addressing problems for WGPs who are living in rural or remote locations because of their partners' work. The GPs surveyed would prefer to work fewer hours and almost "half of all medical practitioners intend to, or may, leave their practice within five years" (McEwin 2001, p. 4).

The Rural Workforce Agencies in all states and the Northern Territory also surveyed WGPs to follow up a range of research initiatives undertaken during the 1990s, these being:

- The National Rural General Practice Study in 1996-1997 that built gender analysis into its design and disaggregated the data by sex and age (Wainer 2001, p. 1).
- The 1996 AMWAC analysis of workforce data which focussed on how, why and where women practised medicine (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1996).
- A report on the rural and remote medical workforce (Australian Medical Workforce Advisory Committee 1996).

The National Rural General Practice Study showed that replacing female doctors leaving rural practice occurred at a much higher rate than in did for male counterparts. The aging rural General Practice workforce, the decrease in the number of years spent by GP in rural practice and the increasing proportion of rural and remote WGPs emphasised the need to target incentives and support programs towards the requirements of female rural doctors (Strasser et al. 2000, p. 225).

A 1997 report on Educational and Support Needs of Female Rural General Practitioners outlined the difficulties faced by rural WGPs, including role-conflict, lack of social support, lack of access to continuing medical education, and problems relating to personal health, safety, and gaining the breadth of professional experience and work practices (Tolhurst et al. 1997, p. 49). The significance of this report was highlighted by the 1998 AMWAC Report on workforce participation which noted that women were under-represented in some areas of medicine, particularly surgery and rural medicine.

The Rural Undergraduate Steering Committee had funded Monash University, Melbourne since 1996 to pilot and introduce teaching on gender issues in the medical curriculum. This project has since been expanded and is available to the undergraduate curriculum of other Australian Universities (Monash University 2004, p. 1). An International Symposium *Increasing Rigor in Medical Education: an International Symposium on Teaching about Gender in Medicine* was held in 2000 in Melbourne. The aim of the symposium was to establish the core content for teaching gender issues in the medical curriculum. The Medical Faculty of Monash University

was the first in the world to commit to mainstreaming an evidence-based gender perspective throughout its medical curriculum. Gender is not limited to women's health issues, rather the impact of gender on health presentations, interventions and outcomes is systematically identified (Monash University 2004, p. 1).

The NSW Rural Doctors Network funded a literature review conducted by Levitt in 1999 which provided background information for the 2000 Victorian survey (entitled *It's where we live*) of the lives of female rural doctors. The survey concluded that rural medicine had taken the lead on gathering information on professional training and structures needed to attract and retain women into rural medicine. It also found that

> ...women have a cyclical relationship with their profession, and require structures and systems that recognise and value the way they experience their lives as women and doctors (Wainer 2001, p. 44).

In 1999 the General Practice Partnership Advisory Council endorsed a recommendation from its Rural Sub-Faculty that a Female Rural GP Working Party be established to develop practical strategies to support the recruitment and retention of female GPs in rural practice. To inform the Working Party the Department of Health and Aged Care contracted the University of Newcastle to undertake the National Female Rural General Practitioners Research Project (Tolhurst and Lippert 2001, p. 1). This project drew on interviews with 114 female GPs in rural and remote locations, the RACGP's St. Hilda's Resolutions (described later in this

Chapter) and the surveys undertaken by the Rural Doctors' Networks in NSW and Victoria. The key findings in this research focused on the need for:

- Additional strategies to support female GPs in balancing their family practice responsibilities.
- Making training and work arrangements more flexible.
- Reducing professional and social isolation of female GPs.
- Underpinning a cultural change in medical practice that valued and respected female GPs skills and work practices (Tolhurst and Lippert 2001).

The 22 recommendations made in this research were endorsed by GPPAC. The Commonwealth Government provided funding to a Rural Female GP Network Steering Committee in 2003 to identify ways to build the capacity and processes within GP organisations to support female GPs, and to develop and sustain future networking activities and functions not dependent on continued Commonwealth funding (*pers. comm.* Geraldine Velez, Project officer of the National Rural Female GP Network Steering Committee).

A Commonwealth Department of Health and Aged Care General Practice Evaluation Program was established by Monash University in 2000 to conduct a national survey on models of practice of rural WGPs. This study documented a range of strategies that might be used by female rural and remote GPs to ensure sustainable practice including updating professional skills, restructuring medical practice, engaging the community, establishing personal and professional boundaries and gaining exposure

to rural environments. It was also reported that women were putting into place professional and personal structures for sustainable rural and remote practice and these structures could be appropriately supported by their professional organisatious (Wainer et al. 2001, pp. S46-48).

The Commonwealth Department of Health and Aging provided a grant to the New South Wales and Victorian Rural Workforce Agencies (2000) on behalf of all Rural Workforce Agencies to establish a national database from the results of the State surveys, and to propose further strategies to increase the participation of females in the rural and remote workforce. The resultant database was "unique in that the data was obtained using one survey tool and has resulted in the development of the first national rural and remote female GP profile" (Doyle 2003, p. 7).

Recurring outcomes resulting from these surveys were that WGPs in rural and remote areas required flexibility in the workplace, support networks, self-empowerment, being valued, accessible training and equality. The top three issues for rural and remote WGPs that came from the surveys of rural and remote female GPs conducted by the Rural Workforce agencies between 2000 and 2003 were personal and professional isolation, accessible and affordable childcare and the demands of the job. Other important issues were the provision of childreu's educatiou, partner's social and professional needs, accessibility to flexible training and CME events and safety in the workplace (Doyle 2003, p. 7).

### 2.3.13 World Organisation of Family Physicians (Wonca) and WGPs Working in Rural Practice

Australian rural WGPs have played a role in developing the Wonca Policy on Rural Practice and Rural Health and in the international activities of Wonca with respect to female rural practitioners. Workshops at the Wonca World Rural Health conferences in Durban 1997, Kuching 1999, and Dublin 1998, considered the theory that women and men practice medicine differently. From the Durban conference came a Policy on Rural Practice and Rural Health, with recommendations that women be involved in the planning and presentation of Wonca Rural Health conferences, and that women's health and gender issues for the rural workforce form part of the program of subsequent rural health conferences in Kuching, Clagary (2000) and Melbourne (2002) (Doty 2004, p. 5).

At the 4th World Conference on Rural Health in Calgary the essential contribution made by women in rural practice was highlighted with recommendations that:

- Rural medical practice must be structured to reflect the way women experience their lives.
- Sustainable rural practice for women must be flexible, safe, locally developed and culturally appropriate.
- The promotion of women's involvement in policy development is essential to ensure the inclusion of the contribution of women.
- The work that women do as rural doctors must be appropriately valued and financially rewarded.
- The many contributions of women to rural medical practice must be

included in core medical curricula.

- Women need diversity and flexibility without pressure to conform to existing professional, training and a practice structures.
- Local teamwork and partnership are necessary to ensure that initiatives are developed which are appropriate to the local area (Doty 2004, p. 7).

The Calgary Conference committee made a commitment to the equal representation of women on the Wonca Working Party, conference organising committees and working parties developing policy in issues in rural practice. The conference also supported the development of a Wonca Policy on women in Rural Practice. The Women in Rural Practice group of the Working party on rural Health was established as an outcome of this commitment (Doty 2004, p. 8).

### 2.3.14 The Effect of Gender for Women in Medicine and Law

In an attempt to establish the effect of gender on medical career, Dennerstein *et al.* (1988) documented the professional achievements, practice patterns, barriers and personal lifestyles of women medical graduates and an equal number of male graduates (matched for year of graduation) of the Faculty of Medicine, University of Melbourne (Dennerstein 1988, pp. 3-4). A similar study of graduates of the Law School at the University of Melbourne was undertaken in 1989, so that the difference in the career participation of the male and female graduates of two professions could be highlighted (Dennerstein et al. 1990, p. 4). Although these surveys are dated, they still provide important information about the effect of gender for women graduates in medicine and law.

The mean age of the law graduates surveyed was 38 years and that of the medical graduates, 42 years. More women than men were unmarried for both law and medical graduates and the graduates of both sexes tended to marry partners of high occupational-status backgrounds. Women doctors and lawyers tended to have fewer children (usually one or two) than the men (generally at least three) and the women in both professions were primarily responsible for child-care and domestic tasks. Causes of career interruption for the women included travel, search for a satisfactory position, the career or attitude of their partner, or the care of other dependants or relatives (Dennerstein et al. 1990, p. 5).

Dennerstein *et al.* (1990) reported the age of obtaining admission to practice (25) was similar for men and women in both professions. At the time the surveys were undertaken, 90% of medical graduates were still working in active medical practice whereas only 78% of law graduates were working in legal practice. Of female graduates, 88% were still active in medical practice compared with 73% active in legal practice. Part-time professional employment was undertaken by 32% of medical graduates but only 10% of law graduates (Dennerstein et al. 1990, p. 6 ).

Males worked an average of 52 hours a week in medicine against 50 hours in law, while females worked an average of 36 hours per week in medicine against 41 hours in law. Few women in either medicine or law were likely to reach the upper echelons of their profession, and in both professions women were dissatisfied with the progression of their careers.

Men earned significantly more than women in both professions. Women made np the majority of those who earned up to $50 000 whereas men were more likely to earn more than $50 000. The major factors that affected lawyers' income were the number of years since their first admission to practicc and their occupation. Barristers and partners who were admitted to practice more than 15 years ago earned the highest income. There was a "gender" effect that conld not be explained by the fact that females had less experience or occupied less senior positions (Dennerstein et al. 1990, pp. 7-8).

Dennerstein *et al.* (1990) reported that the most "successful" doctors were those who did not consider the family in making important career decisions, were at least 40 years of age, and male. The least successful were women who were not only influenced by their family commitments but also by their partner's career or his attitude to their careers. Women in both medical and law professions were significantly more likely to than their male colleagues to report that gender had been detrimental to their career and this was especially so for female law graduates (Dennerstein et al. 1990, p. 9). Dennerstein *et al.* reported that the careers of female doctors and lawyers were

> ...more circumscribed than thosc of their male colleagues and arc affected to a significant degree by the interaction of their personal and professional commitment...In order to ensure that all graduates are able to maximize their training and professional opportunities a greater acknowledgement of the interaction of personal and

> professional [lives] on the career is required (Dennerstein et al. 1990, pp. 10-11).

Dennerstein *et al.* (1990) conclnded that women do not have equality in "professions with career structures designed for persons assumed to have others to carry out any home related activities". These authors noted that as female undergraduate enrolments approached 50% "women must make their voices heard to have their career structures altered". Such changes will

> ...benefit both women who will have a chance to achieve their career potential without needing to be 'superwomen', and men who at last will have time to adequately participate in family life. Only then will women be truly equal (Dennerstein et al. 1990, p. 12).

The two snrveys reported by Dennerstein *et al.*, showed substantial gender differences in the professional promotion of graduates, this being a subject for consideration in this thesis.

### 2.3.15 Gender Disadvantage a Cause of Morbidity in Medical Women

Caroline Quadrio in writing of the psychiatric problems of women in Australia and New Zealand (1991), noted the existing problems of gender disadvantage for medical women. She was of the opinion that

> ...gender disadvantage within the profession significantly

> affects the development of women doctors, resulting in morbidity and less than optimal development (Quadrio 1991, p. 95).

Quadrio noted that there was no woman speaker at the Plenary Sessions of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) conference in 1988, although women made up nearly half of the membership of this organisation. She had previously been told at the 1986 annual congress that "speakers are invited on the basis of competence not gender" (Quadrio 1989, p. 342). On seeking an explanation regarding the lack of women speakers in 1988 she was told that "we didn't want to get into tokenism and after all we did invite an aboriginal" (Quadrio 1989, p. 342).

While discussing this situation with colleagues she was told that she had come along to "kick a few...(male gonads)" (Quadrio 1989, p. 344). Later during an address concerning "Sick Doctors" the participants were asked to consider the plight of female physicians whose suicide rate was four times that of their non-medical sisters and whose depression rate was alarmingly high. The structure of the congress according to Quadrio was typical of the context of how medical women spend their working lives; "Women represented half of the participants a the congress yet not one graced the dais" (Quadrio 1989, p. 344).

A1990 study of doctors in Victoria Australia found the suicide rate was about double that expected for all males, and six times that expected for all females (Schlicht et al.

1990, p. 521). The elevation of suicide risk for medical practitioners, especially women, has also been evident in the UK, Canada and the USA (Clode 2004, pp.17-18). The issues relating to self-care featured strongly in this thesis.

### 2.3.16 Discrimination, Harassment and the Dehumanising of Female Medical Students, Interns and Registrars

Female medical students suffer loneliness and isolation. Despite better academic performances they have lower self-expectations and lower self-esteem than males, and this dehumanising is continued into internship, when trainee doctors face savage work rosters (Quadrio 1991, p. 98 ). There is a "hardening" of female medical students who begin as undergraduates with more humanistic attitudes, more caring and more empathy, but learn to approximate more male attitudes (Quadrio 1991, p. 97). The bleak outlook for female medical students reported by Quadrio reflects similar findings in other countries (Roos et al. 1977, p. 345; Hoferek and Sarnowski 1981, p. 401). Redman *et al.* (1994) noted high rates of gender discrimination or harassment reported by women medical students and interns in Australia, the authors concluding that such discrimination on a regular basis may undermine the confidence of its victims (Redman et al. 1994, p. 369).

Wagner *et al.* (1997) also surveyed medical students who had cried during their hospital training finding that 30% cried because they were humiliated or abused by supervising doctors or nurses or because they could not cope with "difficult" patients. Medical students reported that they cried when they were "ridiculed,

looked at with contempt or screamed at". Of the 57% of doctors in the study who had cried, 9% reported being criticised or being screamed at. Being female significantly increased the likelihood of having cried when at work in the hospital (Wagner et al. 1997, p. 14).

A study by Larkins *et al.* (2003) showed that problems in Australia continued when doctors became GP registrars. Over half of GP registrars reported personal or educational problems during their period of vocational training. These problems related to pressure meeting their rural commitments, heavy workloads, family disruptions, relocation, personal stress, and lack of autonomy and choice. The problems the registrars encountered were significantly associated with initial psychological vulnerability and low enthusiasm for training. Larkins *et al.* also suggested that training staff may be unaware of these problems and that ways of improving the situation included better communications, having clear guidelines, and maximising training program flexibility (Larkins et al. 2003, p. 457).

In 1998 Postgraduate Medical Councils were established in each Australian State and Territory in order to support and develop the education and training requirements for junior doctors and hospital medical officers during their prevocational years. The stressors for junior doctors were discussed at the 3rd and 4th National Forums on Prevocational Medical Education, held in1998 and 1999. These stressors were the rapid change of pace of the medical system, spiraling healthcare costs and the demanding nature of the job with its long working hours and heavy responsibility. The emphasis at the forums was on making doctors in universities and hospitals more

aware of their "duty of care" to colleagues and their responsibility to identify those in distress, so that they received appropriate care (Dahlenburg 2002, p. S). The non-professional lives of the junior doctors were not considered, nor was the issue of generational change discussed. The different needs of medical women (and men) were not suggested as possible stressors for junior doctors.

### 2.3.17 The St. Hilda's Resolutions

The RACGP held an Inaugural Women in General Practice Conference and Workshop: Forming a National Strategy *The St Hilda's Resolutions*, in Melbourne in October 2000. The participants included rural and remote WGPs, WGPs from metropolitan General Practice and organisations concerned with General Practice and Government. The 12 resolutions that resulted were intended to form the basis of a national strategy for WGPs and highlighted the following topics for attention:

- Creating flexibility in training and work
- Mentoring women GPs
- Representing women's needs in policy making
- Valuing women GPs
- Creating positive environments
- Addressing financial needs
- Considering professional and social isolation
- Ensuring personal and professional growth
- Supporting leadership training
- Challenging the dominant medical culture
- Encouraging leadership

- Improving women's self perception (Jorgensen 2000, pp. 2-5)

The St. Hilda's Resolutions were not widely promulgated by the RACGP and the RACGP Presidential Taskforce 2000 together with its National Women's GP Reference Group (with over 40 members) and Internal RACGP Network ceased to exist in 2001. The reason for the cessation of this group has not been examined but may have been linked to the end of the term in office of the female President (late 2000) or the subsequent departure of the many RACGP staff associated with the project. There appears to be little corporate memory within the RACGP of the St. Hilda's Resolutions, the work of the taskforce or of the resultant publication "Forming a National Strategy". However, a separate structure within the RACGP concerned with clinical issues of women's health has continued to be supported by the RACGP. The St. Hilda's Resolutions signalled that issues of concern for WGPs were now on the agenda for organisations and Colleges to address

### 2.3.18 WGPs in the Wonca Working Party on Women and Family Medicine

The Wonca Working Party on Women and Family Medicine was established at the 16th International Conference of Wonca in Durban, in 2001. The Working Party advocates for issues of concern raised by women in Family Medicine and General Practice. The Vision of the Working Party is to promote women family doctors in Wonca "to highlight their special contributions and to reduce the barriers facing them, thereby enabling them to reach their full potential and enhance the contribution of all family physicians/GPs around the world to clinical care, women's health,

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education, research and leadership in family medicine" (Candib et al. 2005, p. 2). A Steering Committee was established for the working party on Women and Family Medicine at Wonca in Durban, in preparation for the 17th WONCA International conference in Orlando Florida in 2004 where a formal executive was established and a strategic action plan was developed.

An e-mail listing known as Wonca women keeps WGPs globally abreast of current issues and projects concerning medical women and rural WGPs. A Wonca Working Document has been developed and it included:

- The Beijing Platform for Action.
- The Wonca Women's Leadership Symposium.
- A Monograph and Literature Review.
- The International Women in Family Medicine Survey-a Needs Assessment Questionnaire (Wonca Working Party on Women and Family Medicine 2005, p. 1).

The main themes from the International Women in Family Medicine Survey undertaken in 2004 concerned the challenges for medical women in practice settings, training, and academic leadership. Problems with Family Medicine organisations identified in this survey included lack of institutional respect for women, lack of funding, lack of female role models and mentors, lack of representation for women and lack of linkage between women to support and promote each other. Another area of concern was an established hierarchy that was not based on skill and

organisational politics (Wonca Working Party on Women and Family Medicine 2005, pp. 1-3). As reported in Chapter 3 of this thesis, during 2006 further achievements have been made by the Wonca Working Party on Women and Family Medicine (WWPWFM) regarding issues affecting WGPs and female family doctors.

### 2.3.19 Women in Academia

Although there is a prolific literature on women in academia overseas, little has been published in peer-reviewed journals regarding academic medical women in Australia. According to Kirov (1991) the paucity of women in medical academia and research can be attributed to the difficult career structure, social and cultural factors and discrimination. The career structure and its competitive nature "rests on the assumption that academics will not take time out" (Kirov 1991, p. 39). The time required for training is in the order of ten years for the minimum attainment of a higher degree or fellowship, a time that coincides with that which is generally devoted to raising a family. Hence the dilemma for women:

> A scientific vocation, like a religious one, requires superhuman commitment and dedication. Married females with children have a divided commitment. Therefore they are less creative and publish less. The women who do achieve, the Madam Curies, are either superwomen or achieve at the expense of their personal lives (Kirov 1991, p. 40).

Kirov maintained that institutional problems include alienation of women, lack of

mentors and role models, lack of job security, lack of recognition, encouragement and support for successful professional experiences and independent research. Female résumés, proposals and papers consistently showed that the potentials and accomplishments of women were undervalued by both men and women relative to those with male attribution (Kirov 1991, p. 41). Improving the status of female medical academics requires

> ...a willingness to abandon deeply ingrained sexual stereotypes, a real pursuit of equity in the tenure and promotion process and a commitment to include more women as role models. It must be a conscious decision on the part of senior staff and those in the positions or power (Kirov 1991).

Kirov also proposed that part-time career paths be recognised, and selection committees should have as an overriding consideration the potential of all applicants, not just the quantity of past publications (review of a few selected papers was her a preferred option). There should also be a better recognition of teaching commitments, service components and clinical work by selection committees. The amount of research funding and the number of publications should not be the only factors worthy of academic appointment (Kirov 1991, p. 42 ). As Chalmers said "We must progress beyond the stage at which we can count the women in major Chairs and positions on our fingers!" (Chalmers 1992, p. 762).

Turner *et al.* (1994) reported a familiar theme that "men who occupy academic positions are often able to work long hours because of the support and domestic

organization of their wives" who

> ...assume (unpaid) collateral social and secretarial responsibilities which eases a man's burden, effectively enabling him to offer more work for the institution (Turner et al. 1994, p. 129).

Women academics not only do not have the help of a "wife" but as Turner states, there is often subtle resistance from those women who turn for assistance, the notion being that "If she was really up to the job she would do the requested task herself" (Turner et al. 1994 p 129 ).

Negative factors that are common in a woman's academic career include gender-based stereotyping, role strain and its impact on relationships. The factors underpinning the career development of women are complex, and "the attribution of blame for impeded development solely on biological and reproductive function is convenient and simplistic" (Turner et al. 1994, p. 134).

Turner *et al.* also found low self-esteem to be widespread in academic medical women they interviewed, with commonly-voiced themes of being unworthy, having to prove oneself, and being "on one's guard" (Turner et al. 1994, p. 134). Some women suffered anxiety and guilt if they had time-consuming careers but these women coped with this by reducing their career demands, working fewer hours and turning to less strenuous and demanding areas of practice. A small proportion of

women also gave up medical work temporarily (Turner et al. 1994, p. 130 ).

There has been considerable research reported on General Practice in Australia (Ward and Donnelly 1998; Askew et al. 2001; Shah et al. 2002; Beilby and Furler 2003), but little has been published concerning the roles that WGPs fill in conducting research. Hart (1996) reported that there were very few women with professorial status in medical schools even though there were equal numbers of male and female PhD students in biomedical research at Australian universities. The main hurdle for women in medical research was their inability to progress in the postdoctoral ranks by appointment or promotion to higher academic levels and positions, including in the National Health and Medical Research Scheme (NHMRC). It was suggested that this failure may reflect the conflicting demands on women with their family and partner versus their academic career (Hart 1996, p. 885).

Hart proposed that criteria for appointment and promotion must be sensitive to time spent on family responsibilities or relocation. In male-dominated universities procedural change was necessary to facilitate the representation of women at all levels, including NHMRC committees and appointment and promotion committees (Hart 1996, p. 887). The use of role models aud mentors, especially those senior women who have been successful researchers was also recommended.

A typical day in the life of an academic GP was described by Zwar *et al.* (2004) to consist of attending to research projects. teaching, clinical work, following special

interests, management and administration. The diversity of the roles was not thought to be overwhelming if one worked in a team and was supported by other academic and administrative staff (Zwar 2004, pp. 19-20). However there appeared to be little understanding of the additional roles and responsibilities that an academic WGP performs. If registrars in General Practice are to be encouraged into academic life, then addressing the critical aspects of "non-professional" life must be considered, and changes in the cultnre of the academic environment that go beyond an individual discipline must be made. In this thesis the experiences of WGPs in academia underscore the continuing difficulties faced by females in the university setting.

## 2.4 Conclusion

This Chapter has reviewed the Australian literature and demographics of female medical practitioners particularly WGPs, and has examined the changes in the General Practice environment and operations, and the effects these changes have had on the lives of WGPs. This leads to Chapter 3 where the relevance of the empirical studies in this research to the current lives of WGPs and their socio-political space in organisations and Colleges will be confirmed.

# Chapter 3

## Current Relevance of this Research to the Lives of WGPs in Australia

### 3.0 Introduction

Although there has been a delay between the collection and submission of the data reported in this thesis, and between its submission and revision, more recent literature (2005-2006) has served to underscore the continuing relevance of the outcomes from the Delphi Study and the Semi-Structured Interviews to the lives of WGPs in Australia. This chapter will focus on these outcomes including the themes of relationships, self-care, professional workplace issues, the difference between men and women, power, patriarchy, generational change and socio-political space that WGPs occupy in medical organisations and Colleges, as related to this recent literature.

Currently most of the studies on women doctors and the problems they face come from Europe and North America, however Candib (2006) argues that with the increasing number of developing nations in Wonca and the increasing number of women doctors represented in Wonca member organisations, "we will soon be able to understand whether women physicians around the world share the same challenges in caring for themselves, [their work] and their families" (Candib et al. 2006, p. 6).

## 3.1 WGPs' Relationships and Self-Care

The WGP participants in this thesis identified that their relationships with their partners, children, family and friends was a key issues in their lives. The topic of childcare emerged as one of key importance to the WGP participants in the two studies undertaken for this thesis. An AMWAC report *The General Practice Workforce in Australia Supply and Requirements to 2013* (2005) refers to the increased number of female WGPs and they extrapolate this to mean that child-care services are needed. This AMWAC report noted that these services are hard to access in many areas so GPs may be reluctant to move away from urban areas where family supports are available. This issue of child-care was repeatedly raised by the WGP participants in this thesis (Australian Medical Workforce Advisory Committee 2005, p. 17).

The AMWAC report (referred to above) also reiterated that there is a lack of high quality and affordable child-care options in rural areas which is particularly problematic for WGPs (Australian Medical Workforce Advisory Committee 2005, p. 23). There is no mention in this report (as there is in this thesis) that many younger male GPs are currently taking responsibility for child-care. Since the difficulty in accessing high quality and reasonably priced child-care is a problem for all parents it has remained on the national agenda to the present time (McBride 2005; Overington 2005; Toomey 2005).

A model of child-care discussed in this thesis that directly benefited WGPs, especially those who were on call, was the nanny model. However, payment of the nanny is very expensive. As Overington suggests, the Federal Government has previously resisted subsidising the nanny model of child-care on the basis that they believe that nannies were mainly employed by rich people. Recently government opinion has changed to considering supporting a wider variety of child-care models including, nanny care, family day-care, child-care in the workplace, at-home care and crèches (Overington 2005, p. 23). An important issue that continues to need attention is, what should be done in policy and service delivery to ensure the availability of the best care taking environment whether the child is at home or in child-care in an urban or rural location.

In this thesis WGP participants recognised the importance of self-care but had difficulty finding time for it. Serious threats to self-care and doctors' well-being continue to be considered in the medical profession. The intent of the profession is to assist those male and female doctors who suffer health problems and establish how these problems can be prevented. In the recent past discussion has included doctors' suicide (Kron 2005) and how to attain self-care and prevent violence (Clode and Boldero 2005; Kramer 2006). However, as to why women doctors have higher suicide rates than the general female population still lacks evidence (Candib et al. 2006, p. 6).

## 3.2 WGPs in the Professional Workplace

The way medical practices operate has been a topic of continuing concern for WGPs, and this is inevitably linked to the need for WGPs to set priorities and to find balance in their lives. Since there has been a worldwide increase in the number of women in medicine in recent years, particular consideration is being given to examining how these issues affect women doctors and female medical students. When the profession, governments and the community are discussing younger generations the focus of discussion has increasingly turned to professional relationships, the culture and the operation of medical organisations and Colleges. While these issues apply to both males and female doctors and medical students, those issues particularly applying to WGPs are the focus of this chapter.

A Victorian WGP, Leanne Rowe, is reported as saying that "[When] talking to women with young families, what we are finding is that they will not compromise their relationships with their families. So...they are choosing to work minimum hours and they are not working after hours" (Walton 2005, p. 2005). Candib (2006) highlights the complex issues that make up the lives of medical women and acknowledges the many challenges that exist but remains optimistic that by juggling work and family WGPs can lead a full rewarding life. Candib claims that lower rates of depression and increased life satisfaction exist for women doctors who have partners and children compared to single women doctors without children. Many female doctors are likely to marry medical partners and work part-time while their

partners work full-time. These dual marriages tend to be long lasting, possibly due to their shared interests and involvement in medical work which keeps the relationship interesting and vibrant (Candib et al. 2006, p. 6).

As noted by Canbid, the dilemma for the WGPs trying to find balance their professional lives is that this is frequently seen as letting colleagues down, the result being a slower advancement in their careers relative to male colleagues. The alternative of cutting back on family time causes domestic relationships to suffer. Medical women are pressurised to be good mothers, good housekeepers and good partners while at the same time performing professional duties and having a meaningful role in society. As noted in this thesis, (supporting and extending the conclusions of Canbid), this attempt at balance results in time-management issues, role conflict, fatigue, burnout, depression, stress and guilt for WGPs.

However the theme of long hours worked by WGPs continues to recur. A disproportionate increase in the pastoral and counselling work performed by WGPs was noted in the 2005 AMWAC report, and this "could create an imbalance within a practice with female GPs working fewer hours, but seeing patients who require longer consultations" (Australian Medical Workforce Advisory Committee 2005, p. 16). This report also noted that although an increasing number of GPs are female and many wish to work part-time, the hours of part-time work are often almost equivalent to full-time hours for the general workforce (Australian Medical Workforce Advisory Committee 2005, p. 17). As noted by Cole (2005), this work tends to result in relatively poor remuneration, and this is a significant underlying

cause of the deleterious outcomes mentioned above (Cole 2005, p. 10). Poor remuneration is in part linked to WGPs performing more extended consultations than male doctors and this finding echoes one of the significant themes that emerged in this thesis. Cole (2005) concludes that respect needs to be developed between male and female GPs for their different but complementary work styles (Cole 2005, p. 10).

Stress in the workplace is a recurring topic both in the literature and in this thesis. Allen (2005) noted that the medical profession has been slow to adapt to the fact that women have accounted for over half of the medical students, yet women doctors find achieving a work-life balance particularly stressful. Drawing upon a rich life experience, women doctors have much to offer especially in the second half of their careers, and should not be prevented from achieving this by rigid career paths (Allen 2005, p. 571). Allen claims that stress at work has consistently been related to lack of control over the working environment. For male doctors the issues that cause stress mainly include lack of autonomy, loss of control over their work environments, concern about targets, conflict with managers, poor support service and inefficient back-up systems. Women doctors experience the added stressors (in excess of male counterparts) of time management, lack of mentors and role models, juggling work and family, lack of social life, working long hours and male domination (Allen 2005, p. 570).

Canbid (2006) maintains that women's stressors relate to traditional roles, relationships and family responsibilities while men's stressors relate to relationships with patients and clinical pressure. Women's roles contain stressors that include

conflict between the marriage partners and parenting, prejudice and discrimination, (either due to gender or family responsibilities), token status, sexual harassment, social isolation, lack of role models, and inadequate family and institutional support. In the training environment and the professional medical workplace, stress is related to competitiveness, power politics, lack of autonomy and lack of control over work hours. The consequence of these stressors is a lack of self-confidence for WGPs who strive to find ways to obtain psychological and emotional support in their personal lives and work settings (Candib et al. 2006, p. 6).

Murfett (2006) reported that GPs having sufficient social support in their workplaces or homes had a better sense of well-being than those who did not. Those GPs who expressed negativity about an adversarial workplace felt less able to help their patients and were more likely to be discouraged and have a poor sense of well-being. Murfett cites earlier work claiming that good relations with a spouse and children can protect against workplace stress and psychological distress such as anxiety, depression, and loneliness compared with people with less support (Murfett 2006, pp. 748-750).

The AMWAC report *Career Decisions Making by Postgraduate Doctors* (2005) noted a significant association between elevated stress and a lack of time for family, social and recreational activities as well as unsatisfactory working conditions and environment. Having sufficient time for developing skills in research and other areas and accessing high quality education activities was also important to postgraduate doctors. Among the reasons stated by young doctors for reducing hours of work and

working part-time were the prevention and reduction of stress, the prevention of burnout, having opportunity to care for children, having more time to spend with family and friends and having the chance to achieve a balanced lifestyle. When selecting the location of their workplace postgraduate doctors of both sexes took into consideration their family, friends, children's education, partner's career and their own career opportunities (Australian Medical Workforce Advisory Committee 2005, pp. 4-10)

A positive trend appears to have developed for WGPs in recent times compared with the situation that existed for WGPs at the time of undertaking the two research studies reported in this thesis. Women doctors are learning to negotiate more effectively the division of labour in domestic duties with their spouses and are developing new strategies tn cope with medical duties such as being on call (Fogg 2005, p. 45; Candib et al. 2006; Overs 2006, pp. 47-48). In medical school, residency and later in medical practice, medical women are using strategies such as networking and methods of working within the system to balance their conflicting priorities. They are also taking part in assertiveness training and programs for developing leadership and mentoring skills, as well as working to improve policies relating to equity in the workplace, parental leave and flexible hours (Candib et al. 2006, p. 6). In addition WGPs are seeking improved remuneration (especially for the long consultations they perform), as well as suitable employment contracts and improved working conditions. They also want to have better job security and better medical indemnity support (Blakemore 2005, p. 6; Cole 2005, p. 10). The comments of WGPs noted in this thesis, that women have a different style of work than men,

has been reflected in a recent comment by Hingston (2006): Female GPs think differently, work differently and treat differently" (Hingston 2006, p. 4).

Not surprisingly rural medicine and education is regularly reported upon. Tonta (2003) claimed that rural medicine must be made attractive to future generations of medical students. Positive experiences in rural General Practice especially in the early years can be vital for students and doctors who are interested in considering a General Practice career in a rural location. As reported in this thesis, WGPs related distinctly negative and damaging experiences that they had experienced during their time as rural GPs, which contrasts with the claim by Tonta that the pleasures of lifestyle of a rural location gives balance to the long work hours, on-call commitments and lack of opportunities for family education and spouse employment. Tonta suggests that job sharing and working part-time will go some way in making rural practice more manageable and less stressful (Tonta 2003, p. 2), although such approaches do not always appear to be realistic from the feedback provided by the participants in the research undertaken for this thesis.

There would be no disagreement with Tonta's suggestion that the community needs to be educated that rural male and female GPs need to have private time for self and for family to prevent burnout, or that mentoring- and gender-issue programs may help to make the rural General Practice option attractive for WGPs and female medical students. Tonta also recognised that men and women have different work practices and priorities to male counterparts (Tonta 2003, p. 2). The WGPs participating in this research were drawn to rural practice largely because of its sense

of community, opportunity for holistic care and diversity of clinical work. The rural WGPs particularly focused on the negative culture of some male GPs in the rural setting.

The issues of safety and stalking were raised by the WGP participants in this research. Manca (2005) noted that while all doctors are vulnerable to stalkers, stalking WGPs is more common than we realise. Manca provided some helpful strategies to deal with stalking, such as recognising and addressing the behaviour early, seeking assistance and documenting all incidents in a separate file that includes tape recordings and other material. Harassment of male and female GPs was reported to exist in many forms, including via telephone, letters, e-mail, unsolicited gifts, stalking, surveillance, property damage and ordering or cancelling services on the victim's behalf (Manca 2005, pp. 640-642).

Other recent Australian studies regarding GP safety have shown that the threat of violence has had a significant impact on the delivery of after-hours care. Female GPs were more apprehensive about providing this care, including home visits, because of the threat of verbal or physical abuse (Blakemore 2006, p. 13). Hayes reports a University of Newcastle study of GPs which found that approximately two-thirds had experienced violence in the previous year, including 9% of GPs who had been sexually harassed and 2.7% who had experienced physical abuse. Those at greatest risk of violence were female GPs, less-experienced GPs and those working in lower socio-economic areas. The risk of violence had an adverse impact on

provision of services including those provided by WGPs, especially after hours (Hayes 2006, p. 2).

In 2006 a Victorian WGP, Dr Maarouf-Hassan, was murdered while working in her general practice. This tragic event has galvanised both male and female GPs and medical organisations to address the issue of General Practice safety (Richards 2006, p, 17). As noted in this thesis harassment and violence were reported by the WGP participants as perceived threats, especially during home visits and after-hours care.

## 3.3 Generational Change

Recent literature regarding generational change confirms the current relevance of the outcomes reported in this thesis. An AMWAC (2005) report *Career Decision Making of Postgraduate Doctors* examines issues of importance for the new generation of male and female postgraduate doctors when selecting their careers and many of these issues are also echoed in this thesis. The AMWAC report includes the following conclusions:

- When choosing a specialty, women give greater consideration to the likely impact of discipline-related work cultures and working conditions on their personal domestic circumstances than do men.
- The number of years to complete training, opportunity to work flexible hours (especially important to doctors who choose General Practice), and the hours of work typical of working in the discipline are of great

> importance for postgraduate doctors (Australian Medical Workforce Advisory Committee 2005, p. 193).

In their workplaces the new generation of male and female postgraduate doctors take account of the existing opportunity for their advancement, better facilities, professional support, access to continuing professional development and a diversity of work including procedural work. They were conscious of stress in the workplace, their level of income, work culture, work experience, and the influence of mentors. They sought a career that provided a stimulating intellectual content and gave them the opportunity to help other people (Harris et al. 2005, p. 295).

The new generation of postgraduate doctors are wary of government policy constraints as they desire the opportunity for choice of location in which to live and work. Lifestyle and access to the arts is very important to postgraduate doctors and entertainment plus sporting activities are among their priorities. The 2005 AMWAC report concerning career selection of postgraduate doctors noted that in 2002 and 2004 women postgraduate doctors rated hours of work, flexible working hours and their domestic circumstances more highly than did men who rated opportunity for procedural work, prestige of the discipline, financial and career advancement prospects more highly than did women (Australian Medical Workforce Advisory Committee 2005, p. 4).

Thomson (2006) reports that medical students plan to avoid the responsibility of owning a practice, but they would rather work in team-based settings and have

access to interests beyond clinical medicine. They also intend to enter specialties that will help to recoup the cost of their training (Thomson 2006, p. 22). Practice ownership has become much less attractive than previously because of the level of financial viability, responsibility required and inability to sell the practice later (Australian Medical Workforce Advisory Committee 2005, p. 19). Interestingly the AMWAC 2005 report found that "the growth in female participation in the GP workforce was compounding this move away from practice ownership, as it was incompatible with their demonstrated preference for flexible working hours" (Australian Medical Workforce Advisory Committee 2005 p20). This could be claimed to be a direct result of the trend noted in this thesis, that WGPs were attracted to other models of General Practice such as being an employee who works part-time or does single sessions for a wage. Countering these observations, or arising from them, there appears to have been an increased interest in business management courses conducted by organisations and Colleges concerned with General Practice (Wilson 2006, p. 35). Yet again, this is in accord with the observations made by some WGP participants in this research, that business education programs would be of benefit in providing information about practice management.

When reviewing the AMWAC 2005 report *Career Decision Making of Postgraduate Doctors* Skinner (2006) concludes that since "medical graduates of today differ vastly from the expectations of their colleagues from previous generations" a better understanding is required of the factors that will allow "the design and [implementation of] work and training practices that recognise and allow for

conflicting professional, family and leisure needs" (Skinner 2006, p. 35). Skinner further noted that with the introduction of postgraduate medical programs in the 1990s, graduate doctors are older, more likely to have partners and dependants and begin their career with a higher level of debt. Hence, junior doctors make career choices on "pragmatic factors, such as income expectations, working hours, length of training time and availability of part-time work, with a sense of vocation being a secondary consideration" (Skinner 2006, p. 35). Essentially, many of the requirements of the junior doctors of the present generations regarding their professional work being organised to complement their requirements in their non-professional lives are similar to those found by the WGPs participants in this research.

Tolhurst (2004) reported that medical students thought that many older doctors had given priority to their work (with the support of a wife at home) over other aspects of their lives, this sometimes resulting in a 'bitter twisted old man syndrome' (Tolhurst and Stewart 2004, p. 363). Clearly they had learned the importance of balance in career structure from the mistakes of previous generations (Tolhurst and Stewart 2004, p. 363) and while current medical students indicated their commitment to medicine they rejected the idea of becoming a 'workaholic' or allowing medicine to become a full-time commitment. Few GPs were now willing to work the long hours outside business hours that were previously taken for granted by the community (Australian Medical Workforce Advisory Committee 2005, p. 17). According to Alexander *et al.* age defines Generation X (23to 37 years) and Generation Y (born after 1980) (Alexander et al. 2004, p. 9). Cole (2006), Tolhurst (2004) and Mackee

(2006) all report that Generation X are increasingly seeking fulfilment in areas other than professional work while trying to achieve a work-life balance and view their work as a job rather than a vocation (Tolhurst and Stewart 2004, p. 363; Cole 2006, p. 18; Mackee 2006, p. 18). Willcock (the current General Practice Education and Training Chairman) has also noted that creating greater work flexibility and improving balance between work and lifestyle is part of the generational changes that has become more evident in Generation X and Generation Y doctors (Anastasopoulos 2006, p. 16).

The WGPs who participated in the Delphi study had a median age of 38.5 years while the participants of the semi-structured interview had a median age of 46 years. Most participants lived as children during the last phase of first wave of feminism and as young adults during the second wave. They are now living through the third wave of feminism together with Generation X and Generation Y. These doctors recognised the importance of achieving balance in their work, family and lifestyle and this has apparently become a priority in the "changing aspirations of Generation Y, which admires commitment to balancing lifestyle and family over duty to one's profession" (Del Mar and Dwyer 2006, p. 32).

## 3.4 Masculine Power, Patriarchy and WGPs in Medical Organisations and Colleges

One of the key themes that arose from the analysis of the semi-structured interviews

was the perceived domination of WGPs by masculine power and patriarchy plus the continuing existence of 'Games Boys Play' and of the 'Old Boys' Network' (Chapter 6). Allen (2005) refers to the 'old boy networks' and 'behind the scenes telephone calls' in the medical selection process and how women who have wanted to reduce their hours of work were not regarded as being proper doctors (Allen 2005, p. 569). The contention that those WGPs who work part-time are not "proper" doctors was also expressed in this thesis.

The conclusions about masculine power and patriarchy reached in this chapter were echoed in a report by Levitt *et al.* (2006), with many of their findings having a familiar ring. The findings of Levitt *et al.* are distilled in the following paragraphs:

- Although the number of WGPs and family medicine doctors is increasing many women continue to face major barriers in their personal, professional and structural lives, this limiting their full participation in organisational leadership and reducing their impact on clinical, organisational and social policies (Levitt et al. 2006, p. 6).
- A primary reason for the disparity between the involvement of men and women in organisational medicine is the pressure of balancing career and family responsibilities in home life as well as traditional gender imbalances in domestic and child-rearing responsibilities. Most organisational meetings take place after hours, further extending the workday and conflicting with women's involvement with their children (Levitt et al. 2006, p. 6).

A lack of mentoring and opportunities for skills development are barriers to women's leadership in Western countries. Leadership programs and mentoring schemes are being held in some countries for junior, mid-career and executive women, while women doctors in senior positions in academic, clinical and research organisations provide important role models for younger doctors and medical students. Medical organisations need to ensure that their leadership style represents the needs of members and reflects inclusive interpersonal styles. Then women will make a professional commitment to participate in this important area (Levitt et al. 2006, p. 6).

Likewise, policies and procedures, bylaws and structures should be examined to identify barriers to women's participation and revised regularly to ensure and monitor equitable participation. Women also encounter discrimination and sexism in organisational medicine and the organisation fails to include or welcomed them. "The 'old boys' network mentality can be extremely destructive and counterproductive." (Levitt et al. 2006, p. 7)

Further, appointment of a few isolated women to formal committees represents 'tokenism'. Women's inclusion appears to fulfil gender equality in representation but does not allow for their full contribution. Organisations can eliminate these discriminatory behaviours by promoting a culture of open and safe discussion, avoiding tokenism and through active promotion of inclusive and protective policies (Levitt et al. 2006, p. 7).

Moving beyond Levitt's important findings, there have been a number of developments in the male/female medical debate that have come to the fore in recent times, regarding the status of WGPs. It is notable that in AMWAC's 2005 document *The General Practice Workforce in Australia* WGPs were listed under the headings of Weakness of General Practice and Threats to General Practice. The valuable contributions that women bring to medicine were not acknowledged. Women were perceived to be a weakness because of "changes in the workforce patterns i.e. more female GPs, working part-time" and a threat because of "working issues i.e. fewer hours [due to] more females" (Australian Medical Workforce Advisory Committee 2005, p. 10).

A common perception is that women are partly to blame for some of the problems that exist in General Practice, such as the decline in GP services. Van Der Weyden (2006) cites a number of issues relating to female doctors that are viewed as detrimental to the medical profession, including shorter medical working hours, the feminisation of medicine, diminished involvement in medical bodies and politics and a lower commitment to work resulting from their desire to balance work and personal commitments (Van Der Weyden 2006, p. 206). However the blaming of women for decreased services in Australia has been shown by McRae to be false. Although GPs of both sexes are providing fewer services than their predecessors, McRae (2006) found that males were primarily responsible for this decline (McRae 2006, p. 123).

Certainly women are under-represented in some medical bodies and politics. For example the 2004 Wonca Executive noted that only one woman was an executive

member, with one other representing a Member at Large. Of all the 89 Presidents of Wonca Member Organisations only 17% have been women. Likewise, of the 69 past members of the World Council, only 15 (21%) were women. In 2006 the Wonca executive decided that if there was to be a better gender balance of equity there needed to be a change in the Wonca bylaws and regulations. It was also decided that mentorship and leadership development programs in Wonca Membership Organisations were needed to promote gender equity at Wonca events and in Wonca office positions (Loh 2006, p. 3). In 2006 the Wonca Working Party on Women and Family Medicine (WWPWFM) undertook to prepare a position paper with recommendations to enhance the contributions of women doctors to the organisation and the profession (Levitt et al. 2006, p. 8).

In August 2006 the Hamilton Equity Recommendations, the HER Statement was published, (a copy of this document is found in Appendix 2) giving WWPWFM responsibility for developing recommendations on how to maintain gender equity within Wonca. The Wonca Executive supported the principles of the HER statement in October 2006. Also in August 2006 the WWPWFM released priority recommendations to improve gender equity, that…

- The principle of gender equity be enshrined within Wonca governance by amending the Wonca by-laws and Regulations, as proposed by the WWPWFM.
- Gender equity be implemented in all activities of Wonca, in particular the scientific program of its triennial, regional, and rural meetings.

- The pivotal role of gender as a key determinant of health be promulgated. (Wonca Working Party on Women and Family Medicine 2006).

Some professional organisations concerned with General Practice in Australia are still struggling with the concept of the roles of women in the organisations. The AMA's Council of General Practice is made up of representatives from state and territory branches and aims to give GPs a voice on major industrial and policy issues. Although women make up 56% of the 2005 applicants for General Practice Training, there were no WGPs on the Council of General Practice. The AMA has recently considered the need to encourage more women to become active on Council and has since set up a membership committee to investigate ways of improving the working environment for female doctors (Blakemore 2006, p. 15; Limprecht 2006, p. 9).

As already stated in the Delphi Study and the semi-structured interviews in this thesis the WGP participants highlighted the need to have a voice and a share of the power in their professional lives. This has clearly not yet happened in many medical organisations, with Eccles (2006) claiming that all major representative groups (AMA, ADGP, RACGP and RDAA) fell short in supporting their GP members (Eccles 2006, p. 2). This is at least now recognised by these organisations, the RDAA professing that it is important to have a balance of male and female members (including board members) and role models to provide grass-roots GPs vision and leadership. The AMA and RACGP have both set up a committee to address the needs of female doctors in a bid to encourage them to remain in General Practice (Blakemore 2006, p. 15). The RACGP's Victoria Faculty Women in General

Practice Committee aims to develop family-friendly support programs, work-life balance, professional development and leadership for women. At an AMA and RACGP joiut forum for women in 2005 WGPs stated that they wanted to be valued in the workplace as part of the practice team, as well as having better medical indemnity support, better remuneration, better work conditions, suitable employment contracts and job satisfaction (Blakemore 2005, p. 6). The WGPs who took part in this researched also sought similar benefits in their professional life.

This thesis has examined the structures of organisations (including universities) concerned with General Practice and questions how they represent and support GPs. Some WGP participants in the research undertaken called for organisational unity to give a strong voice for General Practice. However the current AMA President recently said that while organisations could work together but they are not pulling in the same direction to unite (Eccles 2006, p. 1).

In the domain of universities, Fox *et al.* (2006) highlighted the effect on academic advancement by female members of the medical faculty trying to achieve balance between work and family, noting also that women choose part-time work for childbearing while men choose part-time work for outside employment. Women request tenure rollback to undertake child-care while men request the tenure clock to stop for other reasons. Being male and full-time predicts tenure track selection (Fox et al. 2006, p. 232). Not surprisingly, although academic women are reported to have made substantial strides in the past four decades, a gender gap remains for authors of original articles in prestigious academic medical journals (Jagsi et al. 2006, p. 286).

Academics with spouses or partners who manage the family and household on a full-time basis are becoming more uncommon. As Fox *et al.* (2006) notes:

> If we do not change the rules of the game, faculty members who care about work-family balance will continue to be underrepresented in the senior ranks of academic medicine...Most importantly, the academic climate needs to change from the top. We must actively encourage family members to utilize existing options to facilitate work-family balance, rather than devaluing them for doing so (Fox et al. 2006, p. 233).

In the same vein, Hamel (2006) noted that qualitative studies are needed to assess the professional and personal aspirations of women and men in academic medicine (Hamel et al. 2006, p. 321), since women entering academic medicine are less likely than men to be promoted, or to serve in leadership positions. Hamel claims that institutional barriers to success, sex differences in career, and life goals are important determinants of academic success for women, noting that relatively few women achieve the rank of professor (and the difference is not fully explained by the numbers of hours worked or the number of articles published). Hamel further argues that female faculty members are less likely to have laboratory space and grant support at the start of their academic career, and that women have lower salaries than men with similar experience and academic rank.

Accordingly it may be seen that institutional culture and policy can pose challenges for women since the time commitment required for academic success is frequently

incompatible with responsibilities associated with raising children. Meetings important to career advancement are frequently held outside of working hours, when it is difficult for women to attend (Hamel et al. 2006, p. 311).

Strategies suggested by Hamel to address the inequalities existing for women include initiatives to support and promote women, in academic medicine, mentorship for women by other senior women and demonstrated success in providing equal opportunity and support for female faculty members. It is recommended that these strategies should be included among the measures of job performance for leaders in academic medicine. Similarly, promotion criteria and timelines that are linked to academic productivity and hence promotion processes need to be reviewed as this approach may become untenable (Hamel et al. 2006, pp. 311-312).

## 3.5 Gender Equity for Academic WGPs

When examining gender and academic medicine, Reichenbach and Brown (2004) claim that the gender dimension of enrolment, curriculum and promotion in academic medicine must be addressed. Gender equality in enrolment and graduation rates is not enough, and gender equity will improve the extent, distribution, and skill mix of the health workers. In addition better evidence related to gender and academic medicine is needed and a more focussed mentoring and support system throughout the academic medical process is required. Reichenbach and Brown call for both male and female leaders in academic medicine to rethink their traditional

values to ensure a culture of equity in academic medicine (Reichenback and Brown 2004, p. 794).

As shown in this thesis the goal of WGPs in Australia is gender equity which guarantees fairness and justice in professional opportunities and access to resources, whereas gender equality ensures equal numbers of men and women. Some critics argue that training material in academic medicine endorse a patriarchal view that neglects women's healthcare needs. Adapting the training curriculum to reflect gender, better prepares healthcare providers to address the gamut of health issues and needs for both their patients and themselves.

Recent literature has documented gender inequities in the promotion of academic women. Women advance more slowly than men and there are few women in leadership positions. One explanation for gender inequity in promotion of medical women is that the institutional and cultural structure of academic medicine relies on sponsorship and patronage (Reichenback and Brown 2004, p. 794). As discussed in Chapter 6 of this research, it is precisely the members of the old boys' club who are adept in the art of patronage and sponsorship, but women are less likely to benefit from this benefaction.

Medical school faculties serve as gate-keepers, they influence students selection of specialty and later groom selected individuals for entry into a clinical or academic career. Gender presents challenging issues and crucial questions at all levels of academic medicine. As a conservative, male dominated institution, academic

medicine may not easily examine the gender dimensions of its operation and values (Reichenback and Brown 2004, p. 794). As a WGP in this research noted first it is necessary to examine one's values and self-beliefs but men often find this too confronting.

## 3.6 Conclusion

Examination of the recent national and international literature clearly establishes the continuing relevance of the data reported in this thesis regarding WGP's professional and non-professional life, both in Australia and in the global arena. As described in the Introduction, the themes developed in this thesis make a significant contribution to the current knowledge about the lives of WGPs in Australia and add value to the ongoing debate about key issues that concern the medical profession, governments and the community.

# Chapter 4

## Theory in Qualitative Research as it Relates to this Thesis

> Good qualitative research depends upon a combination of careful research and some imagination and intuition on the part of the researcher in deciding which theory and methodology will provide the best results for the particular topic under study (Rice and Ezzy 1999, p. 26).

### 4.0 Introduction

This chapter discusses the theory underpinning this thesis and the theoretical framework that applies to this research. It also reviews the application of social theory relating to the research studies regarding WGPs in Australia and includes a review of the position and careers of women in the professions and organisations.

### 4.1 Theory

The definition and understanding of what a theory entails and how it is used varies widely among social scientists. As Mitchell noted theory is "one of the most misused and misleading terms in the vocabulary of the social scientist" (Mitchell 1968, p. 211). One definition is that a theory is

> ...a set of propositions about relationships between various concepts. Different theoretical frameworks direct attention to different aspects of a phenomenon (Rice and Ezzy 1999, p. 11).

We can attempt to give more precision and understanding to the concept of theory if theory is regarded as an attempt to account for a given phenomenon, that is "to show what, how and/or why it is, then it can be equated with 'explanation' of social events" (Lewins 1992, p. 104). Theories with a high explanatory power are able to account for why certain events occurred. In other words they are able to provide a more complete answer to the 'why' question. The social sciences have theories with more or less explanatory power because of the varying need to address the 'why' question (Lewins 1992, pp. 20-21).

As Hansen suggests, "qualitative research is characterised by theoretical plurality" (Hansen 2006, p. 15). Theoretical plurality contributes to vigorous debate about the statements that can be made about the social world, what methods can be used to expand knowledge about the social world and what criteria this knowledge should meet (Hansen 2006, p. 15). The many theoretical frameworks essentially shape the focus of research, and therefore shape the methods and techniques required. There is no single authoritative and agreed-upon set of methods for conducting qualitative research. Therefore, if a piece of research is to be meaningfully understood by other qualitative researchers, the researcher must explicitly state the theoretical tradition and methodological criteria employed. However Rice and Ezzy warn that

> ...some people become obsessed with theory. While it is important to recognise the place of theory in qualitative research, the complexities of the theoretical task should never stop a researcher from asking empirical questions (Rice and Ezzy 1999, p. 11).

Glene and Peshkin (1992) were of the opinion that sometimes theory is considered as the latest version of what we call truth, and it is used in a variety of ways in qualitative research. As they argue, qualitative research is neither invariably nor explicitly driven by theory, but researchers often use empirical generalisation or middle-range propositions to help form initial questions and working hypothesis during the early stage of data collection. As they begin to focus on analysis, they may seek out yet other theories to help them examine their data from different perspectives. Qualitative research may or may not eventuate in statements of theory that are grounded in data. Indeed, some researchers consider the entire process of conducting and evaluating research as inherently theoretical (Glesne and Peshkin 1992, p. 21).

In considering theory researchers are well guided by Hansen's discussion of the difference between grand theory, middle range theory and micro theory (Hansen 2006, p. 14). Grand theories are large, abstract, comprehensive and widely applicable. An example of a grand theory is Marxism. Middle range theory is less encompassing and is useful in providing explanations to guide inquiries about specific phenomena or situations. According to Grbich (1999) the germ theory of disease is a good example as this "can be tested empirically, yet is sufficiently

general to be applicable to a range of phenomena" (Grbich 1999, p. 28). Micro theory consists of a set of hypothetical statement about a narrowly defined phenomenon. These statements are derived from interpretations of unrelated concepts and some people argue that micro theory is not a legitimate theory, but rather a set of propositions, models or hypothesis providing the basic building blocks of theory (Grbich 1999, p. 27). Qualitative researchers may also form their own theories based on their research but it is important that a researcher is aware of the theoretical underpinnings of his/her work.

Theoretical debate from a wide range of disciplines such as sociology, education, philosophy and anthropology is available for use in qualitative research. Each theoretical tradition states what type of knowledge is desirable and how this can be acquired. Different researchers and different projects employ theory in different ways, as theory in a research project is linked to the audience for the research and the motivation behind the research project. In the present research the participants will comprise male and female GPs who contributed to the development of knowledge regarding the professional and non-professional lives of WGPs.

### 4.1.1 Framing the Research

A researcher needs to locate his/her work in relation to the research and writings of others, and this can be thought as a "framing the research" (Hansen 2006, p. 167). In this thesis explanatory research will be undertaken in order to increase knowledge about the professional and non-professional lives of WGPs and hence form new

statements about their lives. In addition the WGP researcher has expertise and a long-standing interest in the subject. Since explanatory research is theory-building, rather than theory-driven, the writing in this research will tend towards greater abstraction and generalisations. This researcher seeks to move away from individual instances in the data and move towards identifying a larger pattern of trends, themes and linkages. In addition other researchers' theories and ideas will be used to develop a theoretically informed scheme to describe the findings.

### 4.1.2 Method Driven Research Projects

When qualitative research is conducted without reference to theoretical frameworks, the researcher takes for granted a particular framework without acknowledging it. This may not be a problem if there is an established research tradition in the field where such issues have been worked through. It may be that an established set of techniques and theory has been used before to examine similar problems and the researcher only seeks similar sorts of answers (Rice and Ezzy 1999, p. 11). Since there have been a limited number of qualitative studies on the subject of WGPs there is a limited tradition of techniques and theories used in this area of investigation. Hence, this researcher considers that an individualised framework should be constructed and used for the purpose of examining the issues concerning the professional and non-professional lives of WGPs.

### 4.1.3 Research as both Theory Construction and Theory Testing

Qualitative theory construction involves ending with a theory rather than starting with it. Theory construction based on a modification of Rose's model, begins with methodology (sample, methods, variables, units of analysis), progressing to fieldwork and results which are followed respectively by conclusions and theory (Lewins 1992, p. 68). There is no initial hypothesis to test and the evidence is not quantitatively measurable. Since sociology is concerned with understanding human social behaviour, the best evidence is individuals' accounts of their own behaviour in their social world.

The distinction between theory testing and theory construction research is more a statement of broad trends rather than firm categories. Most research has elements of theory testing and theory construction. Although it is important to understand the principles of both theory testing and theory construction, in their pure form, all social research is more or less both theory testing and theory construction (Lewins 1992, p. 81). In the present research theoretical activity is directed towards identifying pattern, trends, themes and linkages that will give in-depth information regarding the professional and non-professional lives of WGPs. In essence this is a form of theory construction, rather than theory testing.

Berg (2006) argues that it is possible to incorporate both the research-before-theory and the theory-before-research approach to research models, if a spiralling approach rather than a linear approach is adopted. The components and progression of the

spiralling approach are found in Appendix 3. There is no longer a linear progression in a single forward direction but rather the researcher is spiralling forward, never actually leaving any stage behind. Berg further explains that the research process begins with an idea for the research study. Next the researcher begins to review the relevant literature on the topic and start to turn the idea into a research question or a set of researchable foci. During the spiralling approach the question may shift, change, and take form as the research process unfolds. However, the focus of the research or a series of aims for the research remains. The spiralling process has a degree of fluidity that allows the researcher the flexibility to take a step forward and then a step or two backwards before proceeding any further. Although the spiralling process is not linear in nature, in order to simplify understanding of individual elements of this model Berg explains the stages as follows:

Ideas → Literature Review → Design → Data Collection and Organization → Analysis and Findings → Dissemination (Berg 2006, pp. 24-25).

The concept and elements of the spiralling model fits well with the approach taken in this thesis.

## 4.2 The Application of Social Theory to Research on WGPs in Australia

Although there has been little use of sociological theory in research relating to

Australian WGPs, there have been two recent Australian research studies concerning women doctors that applied sociological theory. Pringle (1998) a contemporary Australian feminist academic wrote *Sex and Medicine, Gender Power and Authority in the Medical Profession* which focussed on women doctors (including WGPs) in Australia and England (Pringle 1998). Quadrio (2001) a contemporary Australian psychiatrist and academic wrote *Women Working and Training in Australian Psychiatry* (Quadrio 2001).

Pringle's book on *Sex and Medicine, Gender Power and Authority in the Medical Profession* was deconstructive in that she treated interview transcripts as texts interpreting them for what they didn't say as well as what they did say. The result was a description of women doctors embodied within feminist theory and the sociology of female work and health (Pringle 1998, p. 3). Pringle has also focused of medical women in a number of her other medical writings e.g. Pringle (1994) and Pringle (1996). In *Ladies to Women: Women and the Professions* (1994) Pringle questioned whether the increased number of women in the medical profession was a gain or had just created another form of discrimination, since women were directed into less desirable sectors of the profession where the work was considered appropriate to their gender as GPs or paediatricians.

The growth in the number of female professionals was explained by Pringle as the emergence of secondary job markets within the professions. A glass ceiling was observed for women seeking access to the top jobs and for women undertaking child-care and domestic work. Pringle noted that as the number of women increased in the

male dominated professions, the literature focused more on gender disadvantage. This could be explained either by the difficulties of reconciling a career with a family or was the result of occupational closure. Pringle used the fact was there was no appointment of female registrars in gynecology in the Sydney King George V Hospital (in 1992) as evidence of existing discrimination (Pringle 1994, p. 205). Pringle concluded that the impact of women on the professions in the next two decades would be significant and that this would happen "in a myriad of ways in a variety of rapidly changing contexts" (Pringle 1994, p. 214).

Pringle (1996) in a study on Australian women doctors argued that the feminist critique of medicine as a patriarchal institution failed to appreciate the impact of women patients or the massive growth of women doctors, especially in General Practice and Psychiatry. She proposed that the movement of women into medicine has created great scope for contesting medical power in relation both to clients and other staff. The presence of women, whatever their attitudes, is associated with different expectations about how medicine should be practiced. "[With] a critical mass of 50 percent or more of new graduates...medicine is under pressure to change" (Pringle 1996, p. 29).

Quadrio's 2001 study on *"Women Working and Training in Australian Psychiatry"* is a feminist interrogation of contemporary Australian psychiatry that examines the structure and organisation of the profession its training processes and practices. The study aims to identify and explain the culture of Australian psychiatry and where and how women are situated in it as practitioners, as trainees, and as patients. Quadrio

provided strong evidence that psychiatry in Australia was dominated by a hypermasculine culture which was detrimental to the needs of both male and female clients as well as psychiatrists (Quadrio 2001, p. vii).

### 4.2.1 The Position of Women in Sociological Theory

During much of the 20th Century sociological theory was dominated by structural functionalism and theoretical responses to these ideas. In 1950 Parson's sex-role theory described a 'frigid role' model for women which was seen to represent 'normal behaviour'. Parsons and McClellend (1960) described "how women ought to be rather than how they were" (Eisenstein 1984, p. 9), arguing that the limitations placed on women by their 'natural inclinations towards domesticity' and their role as wife and mother was dictated by biologically based psychology. Furthermore these roles were considered to be necessary for the stability and proper functioning of society, and women who deviated from their prescribed role in the social and emotional support of male counterparts were regarded as deviant, abnormal or mad.

The two major institutional systems dealing with deviance in 20th Century Australia were the judiciary and the medical system. The medical system concerned itself with individuals who deviated from general social norms. Indeed "mad women were defined as mad because they deviated from social norms" (Matthews 1984, p. 12).

In developing his arguments about the nuclear family Parsons aimed to demonstrate that internal structure reflected its more restricted functions. The male role was

concerned with external linkage of the family to paid work to support the family, while the female role was associated with rearing children and providing the emotional anchor in the home. The menial character of housework was alleviated for women through the emotioual significance with which it was invested and the family produced the human personality through child socialisation. In order that the family did not become isolated the family members needed roles outside the family, the most important being the father's occupational role (Harrington 2005, p. 99).

These ideological stereotypes of the roles of men and women resulted in a demarcation between public and private spheres, with men being the active key players in the more important public sphere, and women being linked to the less important private sphere. Throughout the 20th Century this ideology provided a major contribution to the subordination of women, in particular conservative women who followed the dictates that society set out for them.

The 1960s and 1970s saw an intense series of debates on the relationship between Marxism and feminism. These deliberations remain unresolved. For some, Marxist concepts of alienation, power, oppression and exploitation might have given hope to the lives of women. However Marx (1818-83) did not consider the unique problems of women but rather considered the exploitation of men and women as deriving from the same source (Eisenstein 1979, p. 11). Marx saw women's problems as arising from their status as mere instruments of reproduction and he saw the solution in the socialist revolution. In the *Communist Manifesto* he wrote that

> ...the abolition of the present system of production must bring with it the abolition of the community of women springing from that system i.e. of prostitution, both public and private (Marx and Engels 1848, p. 50).

A key Marxist focus concerned the relation between domestic labour and the reproduction of labour power. As Harrington (2005) suggests, Marxist theory tends to exclude domestic labour from analyses of production, ignoring the preconditions that made wage labour possible. Marxism viewed women almost exclusively in familial and domestic terms as dependents of the proletariat, by extending the concepts of production and labour relations to include domestic production. In Marxist social theory, women as domestic servants of wage labourers and as bearers and rearers of children were to be included in the very set of exchanges that Marx saw defining industrial capitalism (Harrington 2005, pp. 239-239). Neo-marxists who questioned some of Marx's concepts, largely failed to address the hierarchical sexual ordering of Western capitalist society. However it may be seen that some of the criticised aspects of a Marxist analysis inform feminist writers, with Pringle being a good example.

In early theoretical work on Functionalism and Marxism, theorists of all persuasions espoused androcentrism by the devices that Marx identified of exclusion, pseudo-inclusion and alienation (March 1982, p. 100). Exclusion resulted from the focus on male-dominated institutions, or the public sphere. Marx and Weber for example focused attention on social process and activities in which women were only marginally involved.

Feminist critics have focused on Weber's conception of the transition from the personal forms of power to impersonal legal-rational forms of domination. Weber advocated that traditional modes of power were characterised by patriarchal domination, by the rule of the father and the husband of women and children. The power of the patriarch was social in origin. Weber stated that

> ...the woman is dependent because of the normal superiority of the physical and intellectual energies of the male, and the child because of his [*sic*] helplessness (Harrington 2005, p. 235).

Weber saw this form of domination forming the base for subsequent forms of power relations and social formations in bureaucracy, rationalisation and the Protestant ethic. Weber's theorisation relies on a gendered dualism where masculinity is associated with rationality and femininity with irrationality. The theory ignored the body and the mind was dominant. This mind-body dualism was distinctly gendered, associating the body with women (Harrington 2005, p. 235).

We see pseudo-inclusion in Emile Durkheim's theory of suicide where Durkheim treated women as a special case. In *Suicide: A Study in Sociology* Durkheim wrote that man is "almost entirely the product of society", while woman is "to a far greater extent the product of nature" (Durkheim 1897, p. 85). In *The Division of Labour in Society* Durkheim wrote that

> ...certain classes of women participate in artistic and literary life just as men...but, even with this sphere of action, a woman

> carries out her own nature, and her role is very specialized, very different from that of man (Durkheim 1893, pp. 19-20).

A feminist response to a dominant account of social theory of androcentricity, academic theories and research was provided by Carol Gilligan's (1982) ground breaking book *In a Different Voice*. Gilligan's work engages with psychological theories of development, in relation to morality and the self-other relationship. She criticised the repeated exclusion of women from theory-building psychological studies and the tendency to adopt the male life as the norm. In her work Gilligan includes women who were previously left out in the construction of theory and aims to show the limitations of androcentric psychological research for an understanding of development of men as well as women:

> We have listened for centuries to the voices of men and the theories of development that their experience informs, so we have come more recently to notice not only the silence of women but the difficulty in hearing what they say when they speak (Gilligan 1993, p. 173).

Gilligan explains that her research shows that men and women "speak in different languages" that they assume are the same, using similar words to encode disparate experiences of self and social relationships. Arising from studies of men's moral development, morality was constructed as being concerned with justice and fairness, and moral development was seen as the understanding of rights and rules. The individual was paramount and personal achievement, autonomy and separatism were

orienting values "...in the different voice of women lies the truth of an ethic of care, the tie between relationship and responsibility..." (Gilligan 1993, p. 173).

Gilligan observed that in women's constructions, morality tends to be centred on an ethic of care, of responsibility for others, so that moral conflict or problems must be resolved with a view to maintaining relationships with others. Self and others were independent, yet it was relationships with others that were seen as central to life. Gilligan's work indicates that developmental theories in psychology need to be revisited, to re-evaluate the current conceptions of men and women.

### 4.2.2 Feminist Theory

The concept of feminism originated in the 18th Century incorporating the doctrine of equal rights for women and an ideology of social transformation aiming to create a world for women beyond social equality. It is an ideology of women's liberation and embraces the belief that women suffer injustices because of their sex. It is also a social movement, one that gradually improved the position of women in 20th Century Western societies with respect to voting rights, position in the workplace and marriage (Abercrombie et al. 2000, p. 131). Feminism tends to be shaped by peoples training, ideology or race (Humm 1995, p. 94), but is succinctly defined as the "analysis of women's subordination for the purpose of figuring out how to change it" (Eisenstein 1984, p. xii). In all of this, critical reflection by women on their life experience is vital.

Feminist analysis focuses on the lives and experiences of women not as the non-

conformist male counterpart, but as equal members of society with legitimate ways of perceiving the world. It challenges the notion that women's actions and concerns are to be judged against male experiences and preferences, and that only male-produced knowledge and experiences are important for society. Feminists have a commitment to change and re-evaluate their priorities arising from the appreciation of legitimacy and meaning of women's lives. As Little suggests, feminism may also be seen as a political strategy concerned with improving and validating women's experiences and female power. The diversity within feminist movements enhances the development of feminist theory and political activity (Little 1994, pp. 3-4).

Of course, there is no one account of feminist theory. It embraces a range of approaches such as liberal, Marxist, radical, psychoanalytical, socialist, existentialist and postmodern, all of which apply to the dilemma of why men and women are treated differently and how to deal with this in contemporary society. All schools of feminism agree on the central consideration of women's subordination and oppression and are committed to improving their lot. The female gender appears to be a major disadvantage to human relationships. However, the various feminist schools differ in their approach to changing the *status quo*. Consciousness-raising is the classical method osed by feminists.

### 4.2.3 First, Second and Third Wave Feminism

First wave feminism dated from the pre-nineteenth-century and was concerned with the rights of women. Mary Wollstonecraft's *Vindication of the Rights of Women*

published in Britain in 1792 is widely recognised as the first substantial and systemic feminine treatise (Wollstonecraft 1992). In Britain and the USA (1880-1920s) the principal concern was women's attainment of equality with men and feminist campaigns centered on legislative change concerning political and legal equality (Pilcher and Whelehan 2004, pp. 52-55).

Walby (1990) a feminist sociologist argued that first wave feminism in Britain was of central importance in bringing about a change from private to public patriarchy by its struggle for the vote, access to education and the professions, employment rights, legal rights over property ownership, legal rights for married women, and divorce.

According to Beilharz (1991) a marked expansion of feminist scholarship was evident from 1970. Taking women as the reference point of academic inquiry requires a shift in perspective, which has the effect of relativising and destabilising existing intellectual paradigms. Feminist theory has implications not just for the study of women but for all of social theory because it suggests that existing theoretical frameworks which claim general validity have relied tacitly or explicitly on a masculine norm (Beilharz 1991, p. 27).

Second wave feminism marked a new period of feminist collective activism and militancy which emerged around 1968 and which talked in terms of 'liberation' from the oppressiveness of a society defined by patriarchy. This showed that women still had a way to go to secure equal rights and opportunities and it was time to reflect on life beyond the public sphere (Abercrombie et al. 2000, p. 131).

The key struggle concerned the female body itself, its representation and the significance of biological difference. Simone de Beauvoir who in her classic work *The Second Sex* published in 1949 declared that "one is not born but rather becomes a woman" (de Beauvoir 1949, p. 295). This guided new thinking on the way gender differences were perceived so that the chief battle for feminists was against the ideological positioning of women just as their material position was of crucial importance to the first wave feminists. De Beauvoir argued that women are opposed by virtue of "otherness". Woman is the Other because she is not man. Man is the self, the free, determining being who defines the meaning of existence, and woman is the Other, the object whose meaning is determined for her. If woman is to become a self, a subject, she must like man, transcend the definition, labels, and essence limiting her existence. She must make herself whatever she wants to be (Tong 1989, p. 6).

De Beauvoir's *The Second Sex* (1949) and Betty Friedan's *The Feminine Mystique* (1963) were important documents for second wave feminists who were committed to building a body of knowledge which addressed the way women had been marginalised, both culturally and socially. Second wave feminists questioned what equality might achieve and gradually gave greater focus on difference between men and women and the meaning attached to them

Second wave feminists also advocated social change that would make existing social structures untenable, imbued as they were with patriarchal realities. However such a revolution presented obstacles as it involved questioning the fabric of people's lives

and emotional investments. Hence, radical feminists organised in small groups to engage in consciousness raising, direct action, and demonstrations that raised public consciousness.

Second wave feminism saw the emergence of a new radical feminism but there were also key shifts in the politics of liberal and Marxist feminists. They conducted debates on topics that Kate Millett in her text on *Sexual Politics* (1972) termed "sexual politics", a concept that has now become mainstream. These topics concerned family, abortion, sexuality, the sexual division of labour, rape and domestic violence (Millett 1972). Marxist feminists made a more marked shift from classic Marxist principles to a consideration of how gendered relations could fit within a class-based structure. In response to the androcentric nature of social and political power and their alienation from Marxism, some second wave feminists sought to break away from the Left and during the 1970s these women became marginalised. As Ann Cuthroys suggest "it was quite apparent that the Left had never considered women in a revolutionary perspective, expecting us to remain faithful servants and supporters in the great struggle" (Curthoys 1988, p. 11). Although the second wave feminists still drew heavily on Marxist concepts, they were more committed to a women-focused theory.

The second wave radical feminists allowed critical space for lesbians, women of colour and working-class women. However, a mainstream of white middle-class, heterosexual women were reluctant to give anything but token space to dissenting or critical voices. As Alston suggested, some conservative women were alienated by the

stridency with which second wave radical feminists proclaimed the concept of patriarchy. The 'personal is political' became the catch-cry of second wave feminists (Alston 1995, p. 19). Given the unequal power relationships between women and men, both radical and social feminists realised that feminist theory was embedded in a political context that could not be separated from practice. Feminist theory was all about change and this gave a political expression to problems faced in their public and private lives. Radical feminism bridges the gap between the public and private spheres. Previously, sexual issues were personal, but during the second wave of feminism sexual issues were seen as political issues, and so women were able to share their oppression.

In the mid-seventies feminist theory moved from minimising to stressing the differences between women and men. Feminists looked to female experiences as "potential sources of strength" (Eisenstein 1984, p. xii). Feminism has had an important effect on social structure and the recruitment of women into all areas of public life and professions from which they were previously marginalised, including law and medicine. Modern feminism lost its dynamism during the late1980s, but grassroots feminist action had established women's studies programs that led to a third wave of feminism (Pilcher and Whelehan 2004, pp. 144 -147).

Third wave feminism belongs to the new younger generation of women who acknowledge the legacy of second wave feminism but see its limitations. In their view feminism remained too exclusively white middle class. It was also prescriptive, alienating younger women who were made to feel guilty about enjoying self-

expression such as cosmetics, fashion and sexuality, especially heterosexuality and its trappings such as pornography. Third wave feminists claim that the historical and political conditions existing at the time of the second wave do not now exist and do not fit with the experiences of today's women (Pilcher and Whelehan 2004, p. 169).

Naomi Wolf's *Fire with Fire* (1993) fits the third wave mould, particularly in the dismissal of what she calls 'victim feminisation' where women supposedly see themselves rendered passive by oppression. Wolf states that "there is nothing wrong with identifying one's victimization...there is a lot wrong with molding it into an identity" (Wolf 1993, p. 148). Wolf compares how women can approach power under the headings of victim feminism and power feminism. Power feminism is flexible and inclusive. Its core tenets are that:

- Women matter as much as do men.
- Women have the right to determine their lives.
- Women's experiences matter.
- Women have the right to tell the truth about their experiences.
- Women deserve more of whatever it is they are not getting enough of because they are women: respect, self-respect, education, safety, health representation, and money. Those are the basics (Wolf 1993, p. 150-151).

Wolf in common with third wave feminism articulates her perspective as part of a generational shift away from the 'old guard' of second wave feminism.

Third wave feminism is equally popular in modern music, television, films and literature. Being part of feminism's third wave means realising one's own politics through the mass media and popular culture. This is in contrast with second wave feminism where the blandishments of the media were shunned for fear of being absorbed by patriarchal power structures. Third wave feminism is seen as an investment in women who have been successful in a man's world, using the usual patriarchal indicators of success, such as money, and media savvy (Pilcher and Whelehan 2004, pp. 169-172).

Third wave feminists also take more of a global perspective of people's lives while embracing some of the key tenets of second wave feminism. Men and heterosexually are less of a problem to third wave feminism, rather there is the sense of generational conflict, the younger generation claiming its own space and fashioning its own image. It may be argued that Generation X feminism is defined by age more than anything else, yet it has more of an individualistic edge, a suspicion of the politics of identity and a marked shift to lifestyle politics. However, there is more academic commentary to emerge regarding third wave feminism which will broaden its scope at the same time as they attempt to account for its philosophy (Pilcher and Whelehan 2004, p. 169-172).

Pritchard Hughes (1997) reported that feminism presently uses gender as its analytical tool instead of class. When gender is taken as an all-embracing category to examine well-being, it is clear that women have reduced levels of personal, economic and institutional power, and feminist persuasions explain this in different ways

(Pritchard Hughes 1997). Gender is further examined below.

## 4.3 Gender, Sex and Power

Gender has been used in confusing ways to refer to the distinctions between male and female, men and women, masculinity and femininity (Connell 1987, p. 89). There is an overlap between each of these pairs of words and theorists have used gender with various meanings with gender and sex being used interchangeably. However in a strict sense, sex of a person is biologically determined but the gender of a person is culturally and socially constructed (Abercrombie et al. 2000, p. 149).

As Grbich notes, it is the personal masculine or feminine attributes and social characteristics that constitute the gender of an individual; gender is the experience of living as, or in, a female or male body (Grbich 1996, p. 285). These characteristics define and categorise what is feminine and masculine and hence gender differentiates behaviours and attributes from sex characteristics that come from biological identity (Grbich 1996, p. 80).

Power and authority in association with feminine attributes are relatively limited, leading Connell (1987) to argue that gender determines an individual's access to wealth, education, health care and politics, while equality depends upon whether one is born male or female. The central issue for gender relations in society is power, and power is linked with the dominance of the masculine (Grbich 1996, p. 81).

Theorists have addressed the socialisation process through which gender identity was inculcated and maintained, investigating gender hierarchies in such domains as language, education, religion and the mass media. Greer in *The Female Eunuch* (1969) tackles the issue of gender, sex and women's liberation. She maintained that sexual liberation is a part of women's liberation in that a woman who cannot organise her sex life in her own interest is unlikely to reorganise society upon more rational lines (Greer 1991).

In 1978 Chodrow's developmental model proposed that girls acquire a sense of femaleness using an adult female model, while the acquisition of male identity requires boys to separate themselves from, and to reject the mother. Girls thus develop a greater sense of relationship and connectedness to others, which in turn encourages them to become mothers themselves, whereas male identity is characterised by an emphasis on separation, autonomy, and clearly defined ego boundaries (Beilharz 1991, p. 26).

The sex/gender distinction which was central to feminist theory in the late 1960's and 1970's was used to challenge the notion that 'biology is destiny'. It allowed women to insert a wedge between nature and culture and between women's biology and their socialisation. Hence, feminists argued that if gender was the result of socialisation, then it was open to radical restructuring through changes in socialisation practice.

In the 1990s many feminists challenged the sex/gender distinction on the grounds that it privileges sexual difference over other differences such as race and sexual

preference. Queer theory for example offers an alternative way of understanding gender, transgender, lesbian and queer sexualities that challenge the heterosexual/homosexual distinction (Caine et al. 1998, p. 489).

## 4.4 Patriarchy

Patriarchy is an important concept in this thesis. It is historically derived from Greek and Roman law, in which the male head of the household has absolute legal and economic power over his dependant family members, but the concept is currently used to describe the dominance of men over women (Wearing 1996, p. 19). Male dominance has been explained biologically by reference to the natural reproductive functions of women, but sociologists argue that patriarchy refers to social relations. Patriarchy should not be seen as a rigid social system in which all men dominate all women, but rather as a set of social relations that are constantly being reconstituted in response to changing social practice and expectations.

Engels (1972) argues that the origins of patriarchy were linked to the advent of private property and inheritance, which lead to the regulation of female sexuality within a monogamous family unit. Yet, Engel's account has been criticised for its reduction of women's subordination to economic factors and for its inability to account for gender inequality in pre- and post-capital societies (Beilharz 1991, p. 23).

Patriarchy came into feminist discourse in 1970s to describe the system of gendered

domination and male authority by which men controlled women's lives and social institutions. Female researchers of the 1970s documented the male domination of women through violence, control of public and private institutions and resources as well as their having access to better jobs and higher incomes than women.

Kate Millett (1972) insisted that the roots of women's oppression are buried deep in patriarchy's sex/gender system. Millett used the term patriarchy to mean an institution, a governing ideology, a set of institutions (the family, society, and the state), and a kind of society, as in "our society" (Millett 1972, p. 25-33). Patriarchy was historically not biologically created. Millett was concerned to describe rather than explain, and to expound upon sexual domination rather than inequality (Curthoys 1988, p. 84).

Millett defined politics as the "power-structural relationships, whereby one group of people is controlled by another" (Millett 1972, p. 24). In her *Sexual Politics* (1972) Millett argued that sex is political primarily because the male-female relationship is the paradigm for all power relationships (Millett 1972, p. 24). The modes in which patriarchy operates include biology, sexual violence, class and education, and this has transformed contemporary thinking about women's role (Humm 1995, p. 172).

Millett widened the concept of politics to refer to power structuring and showed how patriarchal power creates a sexist society. She argued that sexual politics grounded in misogyny resulted in women's oppression both institutionally and in private. Because male control of the public and private worlds is what constitutes patriarchy,

male control must be eliminated if women are to be liberated. To eliminate male control, men and women have to eliminate gender, specifically sexual status, role, and temperament as it has been constructed under patriarchy.

Millett regarded the family as "patriarchy's chief institution". It was "both a mirror of, and a connection with, larger society" (Millett 1972, p. 33). The family not only encouraged its members to adjust and conform but acted as a unit in the government of the patriarchal state which ruled its citizens through its family head namely the father. Female heads of household were regarded as undesirable and reflected poverty or misfortune. Women tended to be ruled through the family and had little or no formal relation to the state. Patriarchy "granted the father nearly total ownership over wife or wives and children, including the powers of physical abuse and often even those of murder and sale" (Millett 1972, p. 33). Millett alleged that

> ...the chief contribution of the family is the socialization of the young (largely through the example and admonition of their parents) into patriarchal ideology's prescribed attitude towards the categories of role, temperament, and status (Millett 1972, p. 35).

Hence Millett saw strong evidence of how a form of patriarchy sits within all societies and how pervasive was its effects upon family members.

Although Millett looked forward to an androgynous future, she thought that it would only be a worthy ideal if the feminine and masculine qualities integrated into the androgynous person were separately worthy. An

inappropriate mix would combine masculine arrogance and feminine servility whereas an ideal mix would be the strength associated with men and the compassion associated with women (Tong 1989, pp. 96-98).

Going further, Walby (1990) defined patriarchy as "a system of social structures and practices in which men dominate, oppress and exploit women" (Walby 1990, p. 20). The power relations in this domination are not universal in strength or direction. Walby identified patriarchal structures as embracing "the patriarchal mode of production, patriarchal relations in paid work, patriarchal relations in the state, male violence, patriarchal relations in sexuality and patriarchal relations in cultural institutions" (Little 1994, pp. 24-25 ).

Walby made a distinction between public and private patriarchy. Private patriarchy is based upon household production, with a patriarch controlling women individually and directly in the private sphere of the home. Public patriarchy is based principally in the public area such as employment and the state. In private patriarchy the exploitation of women's labour takes place by individual patriarchs within the household, while in the public form it is more collective. In private patriarchy the principal patriarch strategy is exclusionary; in the public it is segregationist and subordinating. The change from private to public patriarchy involves a change both in the relation between the structures and within the structures. Household production is the dominant structure in private patriarchy while in public patriarchy it is replaced by employment and the state. All the remaining patriarchal structures are present in each form but there is change in which is dominant. There is also a change

in the institutional form of patriarchy, with the replacement of an individual form of appropriation of women by a collective one [Walby, 1990 #3335 p24. It will be seen that private and public forms of patriarchy are important dimensions to the lives of WGP participants in the semi-structured interviews undertaken as part of this research.

Ferguson (1989) argued that there has been a shift from "father patriarchy" through "husband patriarchy" to "public patriarchy". This shift represents change over time in primary power relations within different modes of social formation. In the colonial period father patriarchy could be attributed to the father's legal and economic control of his children's marriages and inheritance and through family property vested in sons, but not daughters. In the Victorian era husband patriarchy was related to the institution of the family wage that was vested in the husbands as family breadwinners. The contemporary form of male domination is public patriarchy that constitutes a mechanism through which male power over women is exercised [Little, 1994 #19p.25].

Game and Pringle (1983) view patriarchy in the workplace as a structure that gives some men power over other men but *all* men power over women (Game and Pringle 1983, p. 22). Whitbeck cites Raymond who in her paper on *Medicine as a Patriarchal Religion* expands the idea of medicine as a ritual, an idea proposed by a Latin American-based social reformer Ivan Illich, who agued that the institution of medicine in our society has taken on the function of a patriarchal religion. Illich did

not propose transforming institutions but would rather eliminate them (Whitbeck 1982, p. 128).

Essentially the patriarchal system of male authority oppresses women through social, political and economic institutions. Patriarchy has power flowing from men's greater access to resources and rewards and by the authority structure inside and outside the home. The term patriarchy fulfilled the need for feminists to have a term that expressed the totality of the oppressive and exploitative relations that affect women. Different feminists focus on different features of patriarchy that define women's subordination, be it in reproduction, in material context or division of labour. Feminist theorists used patriarchy as a useful concept for describing Betty Friedan's "problem that has no name" (Friedan 1963, p. 29). Friedan thought that this problem may be the

> ...key to...other problems which have been torturing women and their husbands and children, and puzzling their doctors and educators for years. It may well be the key to our future as a nation and a culture (Friedan 1963, p. 29).

Firestone (1971) defines patriarchy in terms of male control of women's reproduction, addressing the question of why (Firestone 1971). She was interested in locating women's oppression in a material base which for her was the biological human duality in reproduction. She saw biological duality as socially institutionalised in the interests of men. If women were to be free, men must share in human reproduction (childbearing and child-care). Firestone used biological

difference as an explanation rather than a justification (Curthoys 1988, p. 84).

Social and Marxist feminists locate patriarchy in a material context and argue that the capitalist mode of production is structured by a patriarchal sexual division of labour. Radical feminism equates patriarchy with male domination because men have power over women who are sexually devalued (Humm 1995, pp. 200-2001).

Rowland (1988) considered that men could understand and empathise with the reality of women's oppression but they could not *be* female or experience being the "other". However men can help by taking responsibility for sexism, refusing to collaborate with patriarchy and actively fighting it. History reveals many forms of institutionalised misogyny from the burning of witches or widows, to sexual slavery, and trafficking in women. Kathleen Barry (1984) describes it as "cultural sadism", recalling the brutality of patriarchal control, of woman-hating, and of the battle that exists between women and men (Rowland 1988, pp. 8-9).

## 4.5 Women in their Private and Public Spheres

Curthoys (1988) claimed that 'modern' feminists have been critical of the nuclear family household. The oppression of women has been based on women's confinement to, dependence upon, and control by, men within the family. Feminists point out that conventional family arrangements in conjunction with labour market inequality reduce the possibility of personal, bodily, and financial autonomy for

women. Child bearing and child rearing involve financial dependence, and economic inequality is disastrous for shared power relations within families, and for those women who fall outside the family (Curthoys 1988, pp. 104-105).

Feminism also highlights other problems within the family including the presumption of heterosexuality, intensive mothering to the exclusion of other connections with social, political and economic life (leading to loneliness and obsession with children) and the petty tyranny practiced by men convinced of their superior rights on the basis of their sex and earning power. Hence many feminists have advocated the rejection of the nuclear family in favour of alternative living arrangements, thereby enabling women to escape their traditional roles with increased possibilities of childlessness via contraception and abortion. However, some feminists do not want to reject the nuclear family but the task of developing alternatives has not proved to be easy (Curthoys 1988, p. 105).

The stereotypical position of women has been useful in explaining the family as a haven and emotional refuge because it has been women who have provided this refuge. As the family has become more isolated, women have become more isolated within the private sphere, so that social reproduction of gender and sexual inequality are rigidly perpetuated. As a result women in the labour force have the burden of a double day because their domestic work is not defined as work at all (Alston 1995, pp. 22-23). This issue is frequently repeated by the WGP participants in the Delphi study and the semi-structured interviews undertaken in this thesis.

Anne Oakley (1985) explored women's identity as housewives and the factors associated with men's involvement. Oakley argued that three interrelated assumptions about gender and work have shaped the social investigation of social research and theory on women's identity in the household. Women belong in the family while men belong at work, therefore men work while women do not work, therefore housework is not a form of work (Oakley 1985, p. 25). Although the work/family distinction expresses the separation between the two spheres of life brought about by industrialisation, it does not follow that one is the world of men while the other is the world of women. Many women go out to work; many women (and some men) work in the home (Oakley 1985, p. 25). The only difference between employment work and housework is that the latter is unpaid, but because (as mentioned previously) work is not a component of the feminine stereotype housework lacks any conceptualisation in society as work. Oakley's analysis of housework provided the basis for further subsequent investigations on the gendered division of labour in the home.

In the 1980s there was a shift away from the focus on housework to a broader focus on the problems facing women in combining paid and unpaid work. This shift was partly due to the large number of married women entering paid employment and the problems they encountered such as unequal wages, unequal access to positions of seniority, sex discrimination and sexual harassment. In addition, the lack of a unified consensus around issues raised by the domestic labour debate and the campaign for wages for housework, forced some feminists to modify their strategies to include workplace reforms, greater workplace flexibility and increased funding of children's

centers, as well as to lobby for paid maternal leave. These strategies were not only intended to make it easier for women but also to encourage men to take a greater share of domestic work. Women's continued prime responsibility for domestic labour caused feminists to continue to grapple with the intransigent issue of gendered labour in the home and how it more broadly equated to gendered labour in the public workplace. The challenge at the political level is the development of strategies that ease the burden women face in combining paid and unpaid work but do not further entrench the view that unpaid work is women's responsibility (Caine et al. 1998, pp. 71-74).

## 4.6 Sociological Studies Regarding Women's Position and Careers in Professions and Organisations

Australian society has traditionally seen the role of women in institutions and organisations as second to men; men defined the roles and structure of organisations and as the masters molded society to their ends at the expense of women (Wearing 1996, p. 79). Game and Pringle (1983) maintained that masculinity and femininity are socially constructed in relation to each other and when discussing women's jobs we are also discussing men's jobs. Even though biology is often said to be responsible for supposed difference in characteristics and ability, there is nothing fixed about the sexual division of labour. The only thing that remains fixed is the distinction between women's work and men's work as the sexual division of labor is remarkably flexible. Gender is about power and the domination by men (Game and Pringle 1983, p. 16). Power and masculine domination being significant influences

on the lives of the WGP participants in this research.

Game and Pringle claimed that sexuality is fundamental to work practices, and organisational change frequently provokes anxiety in men about the loss of power relative to women. Men's sense of self is affronted if they are required to do women's work, they feel reduced in status and fear that they are seen as weak, effeminate or even homosexual. Men's work has to be seen as empowering and technology and masculinity are very closely connected to this ethos. Women who move into male areas of work are made to feel awkward, are excluded from social activities such as the pub scene, are sometimes accused of sleeping their way to the top, or are denied their sexuality altogether. They may also be subjected to sexual harassment, which is a means of keeping them in their place and ensuring they stay there (Game and Pringle 1983, p. 16).

In order to further examine women's position and careers in organisations and professions it is pertinent to explore other sociological studies that address these issues. Riska (2001) approach this subject by considering the relationship between gender and organisations. The three theoretical perspectives or approaches that Riska uses are the contingent, the embedded, and the essentialist. These theories present frameworks for analysing the medical profession and the position of women in it (Riska 2001, p. 21).

### 4.6.1 The Contingent Approach

The contingent approach represents a view that professions are gender-neutral and that the male-dominated character of professions is a "historical remnant and a cultural lag" that will be corrected as larger numbers of women aspire to academic degrees and positions in the profession (Riska 2001, p. 21). This approach explains the unequal distribution of men and women in the hierarchy of medicine. It assumes that given time the increasing number of women will create a gender-balance or even a female-dominated profession (Riska 2001, p. 25).

Women's ongoing under-representation within some ranks of medicine can be explained by normative and structural barriers. The lag interpretation is expressed in both the normative barrier approach and the structural barrier approach to gender inequality (Fiorentine and Cole p469-496). Such a theoretical approach may be seen to be appropriately critical but still retains hope of the utilisation of women's perspectives and life experiences in ways that enhance existing professions.

#### 4.6.1.1 Normative Barriers

Normative barrier theory is more often used to explain gender inequality and the lack of women in senior and executive positions in the professions. It suggests that there are normative barriers preventing women's advancement in occupations and professions. Normative barrier theory focuses on socialisation processes shaping gender traits and sex or gender roles. It assumes that women have been socialised in

ways that stress the conformity to traditional female values of home, family and children. Even those women who have a higher education and a working life will enter those areas that have family oriented tasks and values (Riska 2001, p. 22).

Socialisation theory has been used to explain the recent entry of more women into Medicine and Law. Changes in gender socialisation and more liberal views of tasks that can be performed by both men and women account for the increase in the number of women in previously male dominated careers. Socialisation theory has also been used to show that the unequal position of men and women within the profession is attributed to gender socialisation and individual career choice.

Riska (2001) a contemporary academic sociologist maintains that socialisation theory as applied to the medical profession has two strands, one that explains the existence of gender differences and another that explains the lack of gender difference. The first strand concerns how young men and women are socialised into traditional gender roles, how gender-related preferences account for career choice and how female gender traits impede professional advancement. The way in which women in medicine are placed in the division of labour is described as a deficiency focus. As an example of a deficiency focus, women have been said to lack competitive traits that are needed to achieve elevated positions or standing in medicine. The second strand concerns an asset focus and explains how the special skills of women leads them to work in caring areas, especially those concerned with children and the elderly (Riska 2001, p. 23).

Another version of socialisation theory is one in which the professional role of the doctor is gender neutral, since both male and female students are socialised in the same way and the content and demand of medicine allows little space for gender-socialised traits (Levinson 1967, p. 64; Martin et al. 1988, pp. 333-334). Professional socialisation takes precedence over gender socialisation and hence doctors display gender-neutral behaviour. The medical profession is presented as a "homogeneous and united body and assumes that any change will affect its members equally" (Riska 2001, p. 23).

#### 4.6.1.2 The Structural Barrier Approach

There are many advantages to understanding the existence of WGPs in terms of a structural approach. The structural barriers of an organisation are thought to be the major reason why women are slow to advance a career pattern within an organisation or a profession. These barriers also explain the lack of women in senior or high-level executive positions. Although the works of Kanter are now dated her observations still apply. Kanter noted that "women populate organisations, but they practically never run them especially the large businesses ad public establishments..." (Kanter 1977, p. 16).

Kanter focused on organisational behaviour related to the person's position and the opportunity structures in an organisation. Some positions were seen to provide opportunity and were usually occupied by men, but others were "dead-end" and commonly occupied by women. Kanter gave the position of secretaries in an

organisation as an example of a "dead-end" job that could be redesigned (Kanter 1977, p. 270).

Kanter argued that there was nothing male or female about the jobs in an organisation, but behaviour regardless of gender was shaped by the position and opportunity structures of the profession:

> Work is not an isolated relationship between actor and activity...[and] jobs and the relations of people to them can not be understood without reference to the organised systems in which the contemporary division of labour operates. Understanding organisations and how they function is key to discovering the ways in which people manage their work experiences...Thus, analysis of a job is not enough, without considering where it is and where its occupant stand in organisational distribution of opportunity and power, on ladders and tracts and spheres of influence. The nature of the total system is important in determining the relationship of any individual worker to his or her work (Kanter 1977, p. 250).

Kanter also suggested that the proportional representation of a social category in the organisation would influence the behaviour and power of those in the leadership positions of an organisation. Women were viewed as tokens in management positions especially if they were in the minority. Tokenism was not a problem for the majority of women in organisations because

> ...they tend to be concentrated in typically "female jobs" [but it]

> becomes an increasing problem for those women who occupy jobs most frequently held by men, generally closer to the top of the organisation (Kanter 1977, p. 283).

Kanter postulated that the first women to enter a formerly "male" field were unlikely to encounter tokenism. However

> ...it is here that the informal factors and subtle behaviours identified and "sex discrimination" come into play, for they are elicited by a situation of unequal numbers...Tokenism can occur even if it was not the organisation's intent to put a women into an 'empty' job for display purposes (the conventional meaning of tokenism) (Kanter 1977, p. 282 ).

Kanter assumed that when an organisation becomes more gender balanced, the proportion of a social category in an organisation would influence the power and behaviour of the leadership group. This formed the basis of Kanter's hypothesis about behaviour in an organisation. However, some critics have argued that it is not the numbers that are crucial but rather the male-gendered character of the organisation.

Other concepts used to explain how women were kept from achieving top positions in organisations dominated by men include "gatekeeping" and the "glass ceiling", this being supported by a protégé and mentor system. The mentor is a senior colleague who provides informal professional socialisation in the secrets of professional conduct and knowledge (Epstein 1970). Women (including female medical students)

were not connected to the same extent as their male counterparts and hence lacked the same degree of informal socialisation and information transfer (Epstein 1970).

Lorber (1993) contended that "there is a glass ceiling on women physicians' upward mobility" within the medical profession that made the top positions male dominated (Lorber 1993, p. 63). Riska concluded that in medicine it was the cumulative effect of constant promotion differentials at all levels that best explained the meaning of the glass ceiling (Riska 2001, p. 24). Once structural problems have been addressed women and men might be treated equally in an organisation. Liberal feminists support this view, but it ignores the fact that individuals occupy a gendered organisation which shapes the behaviour of the men and women regardless of their gender identities. Understanding Kanter's concept of the organisational behaviour and the socio-political space that women occupy in organisations gives a basis for considering the investigation of WGPs professional lives in this research.

### 4.6.2 The Embedded Approach

The embedded approach questions the gender neutrality of organisations or professions. This approach argues that organisations and professions are institutionally linked to gender in society. Some proponents support a binary notion of gender which entails the concepts that not only are there two gender categories (men and women) but that these two categories are of unequal worth (Lorber 1994, p. 35).

The gender system operates through gendered processes and gendered practices. "Gendered processes" signifies the ongoing production of hierarchies of social difference of gender. These processes produce ranking of jobs that some have called "gender queueing" (Reskin and Roos 1990) and "sex-typing" (Epstein 1970), including in the sphere of General Practice (Hinze 1999). As Riska acknowledges sex-typing of an occupation is equivalent to Hughe's concept of "master status". Hughes (1945) cited by Riska, uses male terms for primary membership in the professions and raised the issue of gender as a status, arguing that the male status of the medical profession was male gendered. He conceptualised gender as a status rather than a role as Parsons did, and in this way contextualised gender as a social category related to larger social structures. He also raises the question of the assimilation or perpetuation of the marginal status and identity of women as a group at various levels in the organisation of society (Riska 2001, p. 14). Understanding the embedded approach is useful when analysing the position and experiences of WGPs in the gendered processes and practices that operate in organisations and Colleges.

### 4.6.3 The Essentialist Approach

Likewise, the Essentialist Approach suggests that the professions are tied to the culture of male and female genders. Radical feminists and others who view professions as operating as a patriarchal culture argue that professions apparently have a masculine way of organising work.

In *Witches, Midwife, and Nurses: History of Women Healers* (1973) and *For Her*

*Own Good ; 150 Years of the Experts' Advice to Women* (1978) Ehrenreich and English give classic accounts of a male-dominated medical profession interpreted in patriarchal terms. "It was an active takeover by male professionals" (Ehrenreich and English 1973, p. 4).

Before this takeover, women worked as "wise women" who operated as healers but were commonly labelled as witches, and ultimately suffered under the auspices of patriarchal organisations including Church, State and early medical men. Witches traditionally ministered to the sick and poor, filling the peripatetic role of doctor, pharmacist, nurse, counsellor, midwife and abortionist. They developed an understanding of bones, herbs and drugs such as digitalis, ergot derivatives and belladonna. These drugs later became important therapeutic agents in mainstream medicine. The same witches that were later accused of murder, poisoning and sex crimes were also responsible for helping and healing the destitute and those who had no one else to care for them.

*Malleus Maleficarum* (Hammer of Witches) printed at the behest of the Church in 1486, outlined in detail the procedure for the detection and punishment of witches. Cruel methods of torture were used to dupe a prisoner into confessing to crimes of which they were accused:

> Witches were quite simply accused of being sexual; for in the eyes of the Church, all witches' power was ultimately derived from their 'sinful' female sexuality (Eisler 1987, pp. 140-141).

It was claimed that witchcraft came from carnal lust and induction into a coven was reputed to involve sex with the devil. Witches were also accused of inclining the minds of men to inordinate passion, obstructing their generative force, removing the members accommodated to that act, changing men into beasts and causing abortion (Leeson and Gray 1978, p. 22). These pathologically misogynistic views of women and the Church's moral condemnation of women became a justification for male dominance (Eisler 1987, p.141).

The first execution for witchcraft was in 1497, with the focus quickly moving to the use of potions in midwifery and the fate of infants. The association of the witch and midwife was strong (Ehrenreich and English 1973, p. 12). Their 'flying ointment' contained psychotropic substances from plant origins such as hyoscyamus from henbane, atropine from deadly nightshade and aconite from monkshood (Leeson and Gray 1978, p. 23). The Church demanded that no baby die unchristened or be offered to the devil (a practice of which witches were accused) and from the middle of the 16th Century medical practitioners were required to be licensed by the bishop, and midwives and had to swear an oath before the bishop vouching for their good character and midwifery experience (Leeson and Gray 1978, p. 23).

To the common men and women of the time witches were wise women, but the authorities viewed them as charlatans and agents of the devil with magic power. They represented a political, religious and sexual threat to Church and State (Ehrenreich and English 1973, p. 7) leading to their persecution from Germany to England in the late 16th and early 17th Century. Male medical experts took part in

judging the fate of witches in the company of God and the law, while witches were deemed to keep the company of evil and magic. These campaigns resulted in the violent execution of about 30 000 people (mainly women) across Europe before the laws regarding the persecution of witches were repealed in 1735 (Leeson and Gray 1978, p. 22). A clear outcome of these campaigns was the ascendency of male physicians by the 18th Century, when women practised in subordinate roles as nurses (Ehrenreich and English 1973, pp. 16-17). At that time male doctors monopolised medical practice including obstetrics to the virtual exclusion of women.

Ehrenreich and English argue that people's medicine was a "more humane, empirical approach to healing" while the new male-dominated medical elite practised "untested doctrines and medical practices" and "served the ruling class, both medically and politically" (Ehrenreich and English 1973, pp. 4-5). The character of biomedicine lead these authors to concluded that "professionalism in medicine is nothing more than the institutionalisation of a male upper-class monopoly" (Ehrenreich and English 1973, p. 42), deriving its power from "deep-rooted sexism...sustained by a class system which supports male power". Radical feminists have used the patriarchal view of medicine as expressed in the works of Ehrenreich and English to distrust all centralised processes as not representing the interests of the individual consumers. Rather they support the view that women's empowerment resides in an unregulated market where women can build strength as a strong feminist consumer movement (Riska 2001, p. 26).

Riska presents another view of the essentialist approach to the profession that is

commonly found in research and theories regarding women's leadership and management and organisational theories. This view stresses the dissimilarities between men and women but it also emphasises women's different experiences, values or ways of behaving, feeling, and thinking (Riska 2001, p. 26). The Essentialist Approach is pertinent to the investigation of the differences between men and women and understating the apparently different behaviour and values that male and female GPs have as described in this thesis.

Regarding management and organisational theories, Alvesson and Billings (1997) distinguish between a moderate position that embraces the belief that women can contribute something special to an organisation and that they possess qualifications complementary to those of men (Alvesson and Billing 1997, pp.161-170). Women can bring qualities that men sometimes appear to lack. These qualities include empathy plus a people-oriented and democratic leadership style that can make organisations less hierarchical, and more team oriented (Reskin and Roos 1990, pp. 50 -53). Hence, organisational efficiency in management would be better served by a management style that utilises female qualities such as communication skills, team-work, cooperation and networking (Riska 2001, p. 26). The degree to which this applies to the WGPs and the organisations investigated in this research will become apparent as the research progresses.

An alternative value position puts emphasis on the conflicting difference between male and female values. In feminist theory this perspective has been called cultural-feminism (Evans 1995), defined as "the ideology of a female nature or female

essence reappropriated by feminists themselves in an effort to validate undervalued female attributes"(Alcoff 1988, p. 408).

This view defines women by their activities and attributes in the present culture. It claims that women have a different culture and rationality than men because of their childhood experiences. The female culture nourishes a special bond of womanhood through common experiences and caring. Women should cling to their culture by not integrating into their work the culture of men, but rather they should hold fast to their own values and interests and hence achieve their own goals as women (Alvesson and Billing 1997, p. 168).

It can be argued that these female-specific skills are grounded in a patriarchal gender system assigning women a subordinated position in society (Lorber 1998). Often women are promoted to managerial positions because of their human relation skills. In these positions they solve the conflicts between employees and senior management (Reskin and Roos 1990, p. 51) while male managers attend to crucial economic and technical aspects of the organisation (Riska 2001, p. 28).

The theories and the approach presented by Riska (Riska 2001) will be of value when examining the lives, positions, and key issues of WGPs in this thesis. Those who support the embedded approach argue that women's status in professions or organisations is not just a question of their numerical representation but rather it is one of structures and cultural worlds characterised by masculine views and behaviours. Hence, the world of medicine is not gender neutral, but one characterised

by gendered processes and social practices. According to the essentialist view, medicine is a universal patriarchal culture which needs to be reviewed in an attempt to counter the marginalisation of medical women.

## 4.7 Conclusion

This chapter has reviewed the theoretical framework relevant to the research that will be undertaken in this thesis and the application of social theory appropriate for researching the professional and non-professional lives of WGPs. This chapter has also informed the methodology used in conducting the Delphi Study and semi-structured interviews. It will be seen that there are benefits from utilising all of these insights in explaining the worlds of WGPs. While some may argue for an essentialist account, it appears few in the medical literature and very few in the Delphi study and the semi-structured interview would go this far.

# Chapter Five

## Methodology

> Ways of understanding are integrated works of art created by many minds, like cathedrals, as much masterpieces of the human spirit as the Greek tragedies or the paintings of the Renaissance. Human beings construct meaning as spiders make webs or as appropriate enzymes make proteins (Mary Catherine Bateson 1994, in (Ely et al. 1997) p. 63).

### 5.0 Introduction

This Chapter describes the qualitative methodologies used to investigate the lives of WGPs in Australia and the socio-political space they occupy in professional organisations and Colleges. The use of a multi-strategy approach and the application of history in this thesis are described in the introduction while Chapter 4 examines the role and application of theory to this research.

The Delphi study (utilising the Delphi technique as reported in Section 2 of this Chapter) was conducted from October 1996 to January 1997 and followed by semi-structured face-to-face interviews undertaken from June to December 1998 (reported in Section 3 of this Chapter). Since these empirical studies were undertaken in the 90s the current relevance of the data to the professional and non-professional lives of

WGPs and the space they occupy in professional medical organisations and Colleges is discussed in Chapter 3.

The Delphi study articulated the key issues in the professional and non-professional lives of WGPs by using a national group of 40 WGPs in Australia as expert participants. The life-experiences of these WGPs also enabled them to suggest ways to further explore the outcomes of the Delphi study.

The 25 semi-structured interviews facilitated in-depth exploration of the key issues for WGPs in their professional and non-professional lives, and the socio-political space that WGPs occupy in the Australian medical profession, in particular organisations and Colleges concerning General Practice. These interviews also investigated how medical organisations (professional bodies and Colleges) considered the issues of concern for WGPs and ways of ameliorating the inequities experienced by WGPs. In order to draw upon the breadth of knowledge, skills and experience of the GPs, particularly in senior positions in the medical profession, both male and female GPs participated in the semi-structured interviews. Consequently, they provided significant insights into the circumstances, issues and lives of WGPs and how the key issues raised by the WGPs in the Delphi study were being considered and addressed by the professional organisations and Colleges of which they were members.

# Section 1

## 5.1 Qualitative and Quantitative Research

### 5.1.1 The Difference between Qualitative and Quantitative Research

Creswell describes qualitative research as

> ...an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting (Creswell 1998, p. 15).

Authors often define qualitative inquiry by comparing it with quantitative inquiry. A key difference between the two is that quantitative researchers work with a few variables and many cases, whereas qualitative researchers rely on a few cases and many variables (Creswell 1998, p. 16). As Whittaker (1996) observed, the aim of qualitative research is

> ...to understand what makes actions intelligible and the way in which people make sense of the world, that is, their culture. Qualitative research methods emphasise the rigorous description of the qualities of the phenomenon, rather than enumeration. They aim to produce rich, detailed accounts that leave the

participant's perspective intact (Whittaker 1996, p. 311).

People's understanding of the world and their behaviour comes from their interpretation of events and experiences and this can be explored by a neutral observer using qualitative methods, so that outcomes can be predicted. Quantitative research follows the "positivist" tradition which regards the hypothetic-deductive method as the only legitimate basis for scientific knowledge (Whittaker 1996, p. 310).

Whittaker asserts that quantitative studies use methodologies designed to prove or disprove a predetermined hypothesis, whereas qualitative studies work inductively with comparatively open and unstructured research strategies. To avoid preconceived ideas the researcher must attempt to discover the meaning and multiple perspectives held by those being studied and understand the context in which these are expressed. Analysis takes place in a recursive fashion so that new questions are generated during the research. The subjectivity of the researcher and the possible ways in which the study may be influenced by social background, biases, status and the presence of the researcher should also be considered (Whittaker 1996, p. 311).

Minichiello *et al.* (1995) argue that qualitative research can explore complex situations that cannot be explained by quantitative methods. Characteristics that distinguish qualitative and quantitative research are conceptual, the nature of the phenomena studied and the methodological handling of data. Quantitative research is well suited to discovering facts about social phenomena, and data collected are

reported through statistical analysis. Qualitative research is more concerned with understanding human behaviour from an informant's perspective. Data collected by participant observation and unstructured interviews are analysed by themes that come from descriptions by informants and reported in the language of the informants (Minichiello et al. 1995, p. 10).

Quantitative and qualitative methods are complementary rather than competitive (Jones 1995, p. 2), althongh qualitative methods have been under-represented in General Practice research. Murphy and Mattson (cited in Whittaker, 1996) contended that

> ...to limit the research topics that can by legitimately posed in family practice to those that are open to the hypo-deductive method is to deny the discipline significant sources of knowledge (Whittaker 1996, p. 311).

A parallel with qualitative research is seen in the primary care GP who provides whole-person care, considering not only organic but also social and subjective aspects of patients in the context of their environment and community. As noted in "*Unpacking the Black Box of Qualitative Research*", an editorial in the British Medical Journal (1995), qualitative research remains an abstract concept described as a "black box" and one often dismissed by quantitative researchers (Editor's Choice 1995). In attempting to answer the question of why qualitative research struggled to find its position in health service research it was suggested that

> ...one reason may be that clinical scientists have difficulty in accepting the recent methodologies of social science, in which the generating of hypotheses often replaces the testing of hypotheses, explanation replaces measurement, and understanding replaces generalisability (Jones 1995, p. 2).

Publication and dissemination of qualitative research has been difficult because its different format does not fit into a typical biomedical journal or into the required specification for presentation at scientific meetings. Assessment of proposals for qualitative research and papers for publication is also hampered by lack of agreement on assessment criteria (Jones 1995, p. 2). However support for qualitative research continues to increase, advocates claiming it to be a powerful tool to answer questions in primary care that elude quantitative approach.

Qualitative methods are increasingly used in medical education and in medical education research. In medical education, relationships between teaching and learning outcomes can be better understood by looking at the role of intentions, meanings and beliefs in these relationships, qualitative outcomes being then related to ultimate health care outcomes (Colliver 1996, p. 16). Qualitative methods of research can give new insights to issues not amenable to more traditional quantitative methods of enquiry (Broomfield and Humphris 2001, p. 929).

### 5.1.2 Rigour in Qualitative Research

Carefully conducted qualitative research has methodological rigour that allows

scrutiny and criticism comparable with that of quantitative research. When the basic steps are followed thoroughly, readers can be assured that the findings are credible. The basic steps consist of choosing an appropriate method, sampling in a careful purposeful manner, collecting and analysing data in accordance with recognised standards and creating a theoretical interpretation that is clearly supported by the information obtained from the study (Reid 1996, p. 387).

The term rigour is used to refer to validity and reliability of data collected (Rice and Ezzy 1999, p. 30). Validity refers to whether the instrument or measurement strategy actually measures what the evaluator purports to measure and reliability refers to the consistency or dependability of the instrument or measurement strategy. Theoretical rigour refers to sound reasoning and argument and the choice of methods appropriate to the research problems. Methodological or procedural rigour refers to clear documentation of methodological and analytical decisions, while interpretive rigour relates to the appropriate interpretation of data and embraces an extended discussion of the practice of inter-rated reliability checks. Rigour can also be enhanced through triangulation of data sources, methods, and theories. Rigorous reflexivity refers to honest reporting of the role of the researcher in the research (Rice and Ezzy 1999, p. 35). Further discussion of rigour, reliability and validity is provided later in this chapter.

### 5.1.3 Why Qualitative Methodology was Chosen for this Research

Qualitative methodology was considered to be the most appropriate methodology to

explore the complexities and holistic nature of the professional and non-professional lives of WGPs in Australia. Moreover, (as seen in Chapter 7), it allowed the male and female GP interviewees to express their views regarding General Practice, professional organisations and Colleges in the form of rich, interactive dialogue with the researcher.

It was also considered that the WGPs understanding of their experiences in their professional and private lives together with their perception of the context of their environment would be best revealed by qualitative research. Qualitative research would also highlight insights into the socio-political space WGPs occupy in General Practice, professional organisations and Colleges, and these insights would contribute to the understanding of the issues of concern for all GPs.

### 5.1.4 Reflexivity

The process of reflexivity is important in ethnographic, feminist, post-modern and poststructural research as well as qualitative methodologies (Hansen 2006, p. 59). As Nightingale and Cromby (1999) observe, through the process of reflexivity the researcher becomes aware of his/her contribution to the construction of meaning during the research process, and acknowledges the impossibility of remaining outside of the subject matter while conducting research:

> Reflectivity then, urges us to explore the ways in which a researcher's involvement with a particular study influences, acts

upon and informs such research (Nightingale and Cromby 1999p 228).

Mason (1999) extended the concept of reflexivity by maintaining that research should involve critical self-scrutiny or "active reflexivity". This means that the researcher should constantly take stock of his/her actions and roles in the research process, subjecting them to the same critical scrutiny as the data. Crucially, it is recognised that the researcher cannot be neutral, or objective, or detached from the knowledge and evidence being created, but rather seeks to understand his/her role in that process (Mason 1996, p. 6). Rice and Ezzy (1999) explain that the researcher is part and parcel of the setting, context and culture that he/she is trying to understand, but that he/she must be honest about his/her role in the project (Rice and Ezzy 1999, p. 41).

Personal reflexivity involves reflecting on ones own values, political commitments, wider aims in social life and social identities that have shaped the research. It also involves thinking about how the research may have changed us as people and researchers. The role of the researcher is complex and personal details that may have a bearing on the way he/she conducts his/her research should include age, sex, training and background relationship (if any) to the other participants and/or funding bodies as well as any personal connection with the research topic (Hansen 2006, p. 59). As Berg (2006) says, "the researcher understands that he or she is part of the social world that he or she investigates" (Berg 2006, p. 178).

At the time of undertaking the Delphi Study and semi-structured interviews I was

conscious of the importance of being aware of my professional and non-professional roles as a WGP and of the socio-political space I occupied in professional organisations. This realisation enabled me to understand how my personal opinions and views could impact on the data gathering, analysis and writing in this thesis.

I was a WGP of similar age to the WGPs participating in the Delphi Study and the GPs in the semi-structured interviews who lived and practised during the mid to late Nineties. As such, I was able to experience and understand the many viewpoints and appreciate the environment that the research participants occupied. Like many of the WGP participants I lived in a family situation with my husband and our two children. I could share with the WGPs research participants the importance of relationships with family, friends and extended family. My fortune was to have a supportive husband who was able to take part in the family and domestic activities. The juggling of my career with child-care gave me an excellent insight into the importance of self-care and the difficulty in making time to cater for it.

During the time of undertaking this thesis I was an associate GP in an urban general practice carrying out clinical work as well as diverse and multiple practice management issues. I was also a Senior Lecturer in academic General Practice at the University of Tasmania in Hobart and therefore participated in the activities of teaching, research and administration. This experience enabled me to witness the generational change in medical students and how an academic organisation operated. Working in these two disparate workplaces brought me into contact with the same issues in the General Practice workplace and the academic environment that the

research participants reported. It also made me aware of the socio-political dimensions of gender differences and in particular the difference in the way women worked in order to achieve satisfaction.

I have maintained my membership of medical organisations including the AMA, RACGP, Medical Women's Association, AAAGP and the local Division of General Practice. Over the years I held a number of positions in the RACGP Tasmania Faculty including Chairperson and Provost. I was President of the RACGP during 1998-2000 and this enabled me to extend my experience and understanding of general practitioners, the general practice environment and the operation of the RACGP as well as other national and international medical organisations concerned with General Practice.

These RACGP positions provided me the opportunity to make national contacts in General Practice and other medical organisations which were useful when setting up this research. In particular I gained an excellent understanding of how medical organisations operated and their cultures I also had the advantage of being involved in conferences and activities held to consider issnes that were of concern for WGPs, particularly the 2000 Inaugural Women in General Practice Conference and Workshop resulting in the St. Hilda's Resolutions. My experiences as President of the RACGP acquainted me with the issues concerning WGPs at that time, although my experiences in the RACGP did not have any direct influence or bearing on this present research.

While not having a close personal relationship with any of the research participants I did encounter a number of them as representatives of their organisations during my time a President of the RACGP. I was a trainee (later called registrar) of the RACGP Training Program and undertook the Fellowship of the RACGP by examination during 1979. I received small competitive research grants from the RACGP to carry out the Delphi Study and the semi-structured interviews. These grants were administered by the University of Tasmania and the RACGP was not involved with the research undertaken.

As I have interrogated the text of WGPs' experiences in the Delphi study and the semi-structured interviews and explored the sociological literature, I have come to identify with the women participants in terms of many of the professional and non-professional issues experienced. As Mills suggests these are not just private troubles but public issues (Mills 1977, p. 14).

### 5.1.5 Why the Delphi Study and Semi-structured Interviews were used in this Thesis

The Delphi study and the semi-structured interviews were chosen as two complementary but quite different methodologies that shed light on aspects that form the mosaic of WGPs' lives. The participants of the Delphi study were WGPs who elucidated the key issues in the professional and non-professional lives of WGPs in Australia. The male and female GP participants in the semi-structured interviews further illuminated the key issues in the lives of WGPs and also explored the socio-

political space that WGPs occupy in professional organisations and Colleges.

As mentioned by Pill (1971) in this chapter, the Delphi technique should not be used in isolation but should be used in conjunction with other methodologies and the researcher is advised to keep in mind the caveats regarding the validity of the Delphi technique. As noted in the introduction of this thesis the Delphi study and the semi-structured interviews were components of the multi-strategy approach. The combination of these two methodologies with a historical adjunct strengthened the density, validity and yield of rich theoretical concepts and ideas that emerged as a multi-perspective overview. This increased the robustness of the data arising from the empirical studies. The use of these disparate methods, strategy and techniques such as those used in this thesis contributes to triangulation that allows cross-checks on the validity of findings and concepts emerging from the data analysis. Accordingly the rigour of this research is increased through triangulation of data sources, methods and theories.

# Section 2

## 5.2 The Delphi Study

### 5.2.1 Description of the Delphi Technique

The Delphi Technique is a method of structuring group communication in which

study participants discuss complex problems and give opinions that are progressively refined in the light of the responses of all participants. "It is designed to collect, aggregate and refine judgements made by notional 'experts' on specific problems or topics" (Ellis and Whittington 1993, p. 163).

The Delphi technique is further described as "a multiple iteration survey technique that enables anonymous, systematic refinement of expert opinion with the aim of arriving at a combined or consensual position" (Bowles 1999, p. 1). Jones and Hunter (1995) maintained that consensus methods allow a greater role for the qualitative assessment of evidence and a wider range of study types to be considered than is usual in statistical reviews. The features of such methods are anonymity, iteration, controlled feedback and the analysis of a group response. This group response expresses judgement by using summary measures of the full group response, giving more information than is provided by a consensus statement (Jones and Hunter 1995, p. 376).

The use of a method that allows for consensus will also determine the extent to which people agree about an issue. The degree of agreement of respondents on an issue is typically rated on a numerical scale or categorical scale and assessed by statistical measures of average and dispersion (Jones and Hunter 1995, p. 376). Consensus measurement is advantageous where unanimity of opinion does not exist because of a lack of evidence, or where the evidence is contradictory. The consensus method attempts both to assess the extent of agreement (consensus measurement) and to resolve disagreement (consensus development) (Jones and Hunter 1995, p. 376-377).

Broomfield and Humphris (2001) claim that the overall strength of the Delphi Technique lies in its ability to provide a systematic and structured approach to collating data in relation to the question under investigation, where the only available alternative is an anecdotal or an entirely subjective approach. A major principle of the Delphi technique is anonymity which facilitates the expression of 'true opinion' rather than that of the establishment (Broomfield and Humphris 2001, p. 930).

The Delphi technique

> ...encourages honest opinion which is free from peer group pressure...Because each successive round of information reach each panel member, views can be retracted, altered or added with the benefit of considered thought (Williams and Webb 1994, p. 181).

The technique allows participants to consider their views on a topic in their own time and to provide comment without intimidation or bias that can otherwise arise in committee meetings and group discussions. The iterative nature of the Delphi technique demands identification of ideas followed by their consensus evaluation.

### 5.2.2 History of the Delphi Technique

The Delphi technique takes its name from the Greek God Apollo Pythios who, as master of the City of Delphi, predicted the future through a medium guarded by priests at the Oracle of Delphi (Bowles 1999, p. 9).

The Delphi process was first used around 1948 in an attempt to predict the outcomes of horse races. In the 1950s the Rand Corporation in California used the Delphi technique for the development of defence strategy, specifically in technological forecasting (Pill 1971, pp. 58-59) and a version of the Delphi technique was also utilised to solicit the opinions of experts on atomic warfare and to forecast technological events (Dalkey and Helmer 1963, p. 458). Over 400 references to the use of the Delphi technique in education, social science, health and industry have since been identified (Ellis and Whittington 1993, p. 163).

### 5.2.3 Why the Delphi Technique was Chosen as the Methodology in this Research

Investigating the problems faced by WGPs in Australia has inherently involved using subjective judgements made by a group of notional experts. The Delphi technique was considered to be most appropriate for the purpose in view of the recommendation that this was the method of choice when the problem under study benefited from subjective statements made on a collective basis (Goodman 1987, p. 773).

The Delphi technique has many advantages including the avoidance of group domination by individuals, confrontation, peer pressure, power play, professional hierarchal status or political influence. Lack of consensus relating to group dysfunction is prevented as the origin of an idea is unknown and each idea can be evaluated on its own merit, independent of its sources. The iterative nature of the Delphi technique requires idea identification separate from, and prior to, evaluation

and this prevents premature conclusions being reached.

The participant WGPs in the Delphi study described in this thesis came from diverse backgrounds and from different geographic areas of Australia, and encompassed a wide range of experiences in their professional and non-professional lives. There were constraints on the time available for these WGPs to undertake the study and the geographical distance between them was immense. These factors coupled with the numbers of WGPs involved (40) and the need for consensus necessitated a methodology that avoided any need for face-to-face meetings. Hence the Delphi technique was considered to be the method of choice. The technique had a high degree of acceptability to participants, so response rate was high with 39 of the 40 WGPs completing all iterations requested by the investigator. Interest-levels of WGPs remained high and the flexible timeframe for answering the questionnaires was appreciated. One WGP travelled overseas and consequently was unable to complete all iterations.

### 5.2.4 Accuracy, Reliability and Validity of the Delphi Technique

Criticisms of the Delphi technique in the literature relate to the lack of a standardised method of analysis of the open-ended questions during the first discussion. It is unclear for example whether individuals change their opinions on the basis of new information or, despite protection of anonymity, peer pressure causes them to conform to mainstream opinion. It is also not clear if consensus represents agreement based on considered opinion or the tendency to conform. The fatigue factor of

participants who have taken part in more than three or four rounds may also result in agreement being reached simply as a means to an end. The Delphi Study described in this thesis had only three iterations and fatigue did not appear to be an issue.

The validity of the Delphi technique has long been a cause of concern, Pill (1971) positing that there is really no generally acceptable means of gauging the validity and accuracy of the output of any such procedure:

> The Delphi technique should not be considered in isolation, as it can be used in conjunction with other approaches to solve a wide range of problems, if one remembers the *caveats* regarding its validity (Pill 1971, pp. 5-6).

Sackman (1975) (cited by Crisp *et al.* 1999) argued that the Delphi technique fails to meet the standards set for a scientific method. Although a sizeable literature has been generated by the technique, Crisp *et al.* concluded that the overall result did not reflect a high level of reliability and validity (Crisp et al. 1999, p. 3). It has been said that the Delphi technique lacks established methodological guidelines because the character of the first iteration may affect the outcome. However it has also been argued that the absence of guidelines allows flexibility and tailoring of the technique to specific situations (Whitman 1990, p. 31). Difficulties in establishing the accuracy of the Delphi technique have lead some authors to either state that there is no evidence that the Delphi technique is reliable, or take the view that the question to some extent remains open (Williams and Webb 1994, p. 182).

A potential source of bias in the Delphi technique lies in the choice of participants in a study population. The original Delphi method used 'experts' as respondents (Bond and Bond 1982, p. 567), and not surprisingly the concept and definition of an expert has been questioned by a number of authors. Expertise is a valid construct but it is not easy to identify who possesses it (Bowles 1999, p. 2). Whitman described an expert as anyone with knowledge about a specific subject (Whitman 1990, p. 32), this author snggesting that individuals who offer informed judgement as well as those who give informed opinion should be included in the study. Use of a panel of experts is based upon the belief that the "...professions will have knowledge of the problems they face [and] research related to a specifie field and historical trends...The experts will be entirely conversant with the parameters of their professional practice" (Duffield 1989, p. 42).

A large literature has also been generated in support of the Delphi technique and according to Bowles:

> Its ability to develop qualitative and quantitative data, provide controlled anonymous feedback and its goal of consensus, make it flexible, tolerant to the panellist diversity and forward-looking, even utopian (Bowles 1999, p. 9).

Bowles conceded that the Delphi technique is primarily popular among those who use it and that some health researchers may not have adequately met the challenge of conducting reliable and convincing Delphi studies. It is also clear that numerical,

historical and follow-up designs have often not been adequately explored (Bowles 1999, p. 9).

Although there is a potential for researcher bias ranging from the design of open-ended questions to analysis of the results, this criticism is not restricted to the Delphi technique and Delphi studies are claimed to "generally have more validity and reliability than many other qualitative research methods" (Bowles 1999, p. 3).

The Delphi technique proved to be well suited for the present investigation. The use of replication studies in an attempt to improve reliability and validity (Crisp et al. 1999, p. 3) was not considered to be appropriate in the present study since the responses were from the personal experiences and logistical problems placed such studies beyond realistic consideration. Bearing in mind Pill's (1971) advice that the technique should not be used in isolation, the Delphi study was followed by semi-structured, face-to-face interviews where the key issues in the professional and non-professional lives of WGPs were further explored.

### 5.2.5 How the Delphi Study was Conducted

#### 5.2.5.1 Aim and Objectives

The aim of the Delphi study was to identify what WGPs considered, from their personal experiences, to be the key issues in their professional and non-professional lives. The objectives of the study were:

- To identify priorities and reach a consensus on the key issues.
- To verify important issues for the future and suggest strategies for tackling and dealing with them.
- To establish guidelines about the concerns and priority areas for women in General Practice.

### 5.2.5.2 Ethical Approval

Ethical approval was given for the study by the RACGP's Research and Evaluation Ethics Committee. Participants were assured in writing of their anonymity, that all information collected would be kept confidential and that they could withdraw from the study at any time. Each participant was asked to sign an ethics statement and return it to the researcher.

### 5.2.5.3 Reference Group

Although a reference group is not part of the methodology described for the Delphi technique, in this study a reference group of WGPs enabled the application of a broad expertise to the study as described below. The reference group consisted of four urban and two rural WGPs who had significant expertise in Australian General Practice and were recognised by their peers as being eminent in professional, educational or clinical General Practice. Individual group members were located in Tasmania, the Australian Capital Territory, South Australia, the Northern Territory,

New South Wales and Queensland. The role of the reference group was primarily to assist with the development and appraisal of the study by reviewing and endorsing the overarching questions, the study objectives, and the criteria for selection of the expert participants of the Delphi study. The reference group pre-tested the Delphi iterations by completing them in the same way as the WGP expert participants would be requested to do, thus enabling them to refine their guidelines before the study commenced. The reference group was also able to make certain that any biased or mistaken perception on the part of the investigator could be identified.

As will be shown later in this chapter, the reference group were vital to the selection and contact of 40 WGP expert participants encompassing the breadth of knowledge, experience and demographic representation of Australian WGPs. Finally the reference group provided a critique of the outcomes of the Delphi study, thus suggesting avenues for further research on issues concerning WGPs in Australia. Teleconferencing, e-mail, facsimile and post enabled the reference group to oversee the process of the study and provide wise counsel. Two teleconferences were held, one to undertake the tasks described above, the other to consider the outcomes of study.

Prior to the first teleconference each member of the reference group was sent a position paper describing the study (Appendix 4), the selection criteria for the participant experts (Appendix 5), a copy of the first Delphi iteration form (Appendix 6), a form to record details of the possible expert participants that the WGPs in the reference group would contact, and a form to record the cost of phone calls. They

were also sent a copy of the draft demographic questionnaire for the expert participants and another to provide their own demographic data. Written communication was sent to the reference group before and after each teleconference. An example of this is given in (Appendix 18). During the second and third iteration of the Delphi study, letters, e-mails and facsimiles from the research investigator kept the reference group fully informed of the progress of the study (Appendix 7). Prior to the final teleconference a written report was posted to the reference group describing the key outcomes of the study.

#### 5.2.5.4 Demographic Details of the Reference Group

The reference group comprised six WGPs having a median age of 45 years (range 25-59 years), with a median of 19 years spent in General Practice (range 2-25 years). All six were vocationally registered and living with a partner, two had children aged between 12 and 17 years and one had a child aged less than 5 years. Five members were born in Australia (none was of Aboriginal or Torres Strait Islander background), the other in the UK. Five were FRACGPs, one was an Associate Member. Other than English, one of the members spoke German and one spoke Polish.

One of the members practised in a remote area having a population of 5000 or more, three in a capital city, one in a metropolitan location having a population of 100 000 or more, and one in a large rural centre having a population of 25 000 or more. Two women belonged to the AMA, five to a Division of General Practice, three to the

Medical Women's Association, three to the AAAGP and one to the RDA. Interests reported by the women included church membership, library activities and participating in the Registrars Association of the RACGP. An average of 9.5 hours per week was spent on personal, leisure or social activities and three hours on self-education. One woman was studying for a Masters of Business Association (MBA), while three were undertaking research or scholarly writings and spending an average of eight hours per week on this activity. An average of 22.5 hours per week was spent by the WGPs on domestic duties and a similar time (24.8 hours) was spent doing clinical work.

**5.2.5.5 The Study Population**

The method used to determine the study population in the Delphi study was criterion sampling, whereby the researcher sets up pre-determined criteria of importance. Rice and Ezzy (1994) advise that when criterion sampling is used it is important to select criteria carefully, so as to define cases that will provide detailed and rich data relevant to the particular research problem (Rice and Ezzy 1999, p. 44).

In this Delphi study, a table of categories containing criteria pertaining to aspects of the professional and non-professional lives of WGPs was constructed (Appendix 5). This enabled the selection of an expert group of 40 WGPs with diverse backgrounds, at various stages in their career, and who were living in either urban or rural geographic locations throughout Australia.

The selection criteria for the study participants were based on the background literature but were amenable to suggestions from the reference group. During a dedicated teleconference each member of the reference group was assigned a number of selection criteria and requested to contact WGPs who they perceived to have the knowledge and experience specified in at least one criterion. When a WGP was contacted by a reference group member she was given information about the Delphi study and had the research process explained to her. The WGP was then asked if she would agree to have her contact details provided to the research investigator so that she could receive more information about the study and a written invitation (Appendix 8) to join the Delphi study as an expert participant. Most of the selected expert participants had knowledge and experience in more than one criterion. There was no difficulty in recruiting 40 WGPs to the study.

**5.2.5.6 Demographics of the WGPs who were Expert Participants**

The median age of the 40 WGP experts was 38.5 years (range 25-65), with a median of eight years spent in General practice (range 1-40 years). Twenty two of the WGPs practiced in a capital city, eight in a remote area, five in metropolitan centres and one in a small rural centre, (population 10 000 to 24 999). Four were not practising at the time of the study, 28 lived with a partner and none was of Aboriginal or Torres Strait background. Twenty six of the participants were born in Australia, six in England and one in each of Argentina, Dutch West Indies, Netherlands, New Zealand, Poland, Syria, Uganda and India. The participants had a breadth of language skills other than English; six spoke French, three Polish, three Spanish, two Dutch, and two German,

while other individuals spoke Arabic, Bislama (Vanuatu pidgin), Italian, Portuguese, Russian, Ukrainian or Urdu.

Twenty one of the WGPs held a FRACGP, 30 were vocationally registered and 31 belonged to a Division of General Practice. Membership of other bodies included the AMA (19), the RACGP (26), the ACRRM (1), the RDAA (6), the Medical Women's Society (14), the AAGP (4), and the AAAGP (4). Two of the women were members of the Public Health Association and three were diplomate members of the Royal Australasian College of Obstetrics and Gynaecology.

Special clinical interests included journalism, sports medicine, counselling, public health, family planning, women's health, anaesthetics, sexual assault service, obstetrics, palliative care, youth work and work for the Department of Veterans Affairs. The WGPs were active in a broad range of non-medical committees, associations and professional bodies including those associated with sports, schools, child-care, church, cultural organisations, community-service, academic, clinical and business pursuits. An average of three hours per week was spent on such activities by 22 of the 40 women.

Consultations with patients occupied an average of 25 hours per week and an additional three hours on average was spent by the WGPs on paperwork and administration for patients, including phone calls. Thirteen of the WGPs experts were on call for clinical duties, working an average of 67 hours per week. Twenty five of the participants conducted visits to patients at home, in hospital, nursing

homes and institutions. These visits including travel time amounting to an average of three hours per week. Sixteen of the experts contributed to practice administration, on average two hours per week.

The WGP experts spent and average of 18 hours per week performing or organising domestic tasks, while an average of 35 hours per week was spent on child care or care for other family members by the 19 women who had these responsibilities. Personal pursuits of leisure or social activities occupied an average of ten hours per week. Twelve of the women taught General Practice or rural medicine to medical students or registrars for an average of 4.5 hours a week. Self-education, including quality assurance and continuing medical education occupied an average of 4.8 hours per week for 36 of the respondents. Eight of the women took part in research or scholarly writings, spending an average of 8.5 hours per week on these tasks. Twenty two respondents took part in non-clinical professional activities such as committees or meetings, spending an average of three hours per week on these activities.

Twenty three of the women had children in their household aged 17 years or younger, with an average of two children in those households. Two of the women mentioned having children not living with them or being educated at boarding school.

### 5.2.5.7 The Delphi Technique, Data Collection and Analysis

Several rounds of data collection are required to allow the development and discussion of responses made by the participants and to reach a valid consensus of views on specific issues (Broomfield and Humphris 2001). The basic steps for conducting a Delphi study as described by Ellis and Whittington (1993) are to identify and involve a suitable group and design a package of relevant information identifying problems to be addressed or issues to be tackled. The package is posted to each group member with a "return-by" date plus an assurance that their responses will be kept anonymous in subsequent analysis. The responses are collated and analysed, resulting in a further package of information providing feedback on responses, again requesting responses from the participants. This procedure is repeated until an acceptable level of consensus has been achieved (Ellis and Whittington 1993, p. 165).

In the Delphi study described in this thesis, the postal service was used over three iterations. The Delphi iterations were coded so that individual responses could not be identified. At the outset a coded questionnaire requesting demographic data was posted to each participant together with information on the approved ethical status of the project and detailed instructions relating to its purpose and methodology. The participants were asked to sign and return the ethics statement. Included with each mail-out was a pre-paid envelope for response returns.

The first iteration (round one) requested the participants to identify key issues in their

professional and non-professional lives and to include examples (Appendix 6). Participants were informed that the definitions and examples given to them (and previously endorsed by the reference group) regarding their professional and non-professional lives were incomplete, and intended only as suggestions. Professional life was defined as including a variety of work in a number of workplaces, with numerous people as well as an array of additional factors including time spent on these activities. Examples of activities fitting professional life given to the participants were clinical, academic, administrative, government, busiuess, teaching, research, self-education, Colleges, Divisions of General Practice, special interest groups, politics, community group projects, councils, committees, health consumers and patient care.

Non-professional life was defined to include an array of people, work, activities, places and additional factors that are part of life in society outside the medical profession. Examples of non-professional activities were their involvement with partners, families, colleagues and friends as well as dnmestic responsibilities, child-care, self-care and life-style. The analysis of the responses of the expert participants after the first iteration was achieved by sectioning their replies into individual statements that were then sorted and assembled using headings for each of the themes relating to either professional or non-professional lives. The outcome of this process was the development of a second Delphi iteration.

In the second iteration (round two) (Appendix 9) participants rated ten key issues (in order of importance) in their professional and non-professional lives from those

issues identified in the first round. This enabled a preliminary score to be allocated by the participants for each of the issues raised. The participants were also requested to clarify, comment on, or argue in favour of or against any issue. Individual comments and arguments made by the experts in round two were listed together with a total preliminary vote that matched each key issue identified in round one. This process formed the third and final Delphi iteration (round three) (Appendix 10).

In the third round the participants re-evaluated the scores by casting a final vote on the key issues in their professional life in the light of feedback from the second iteration. Participants gave their highest-rated key issue a vote of 10 and their lowest-rated key issue a vote of 1. The participants were asked to include final comments on the key issues and state how further research or other interventions may help address a particular issue for WGPs. An identical process was followed for the key issues in the non-professional lives of the WGPs. The outcome was a consensus ranking of the most important issues in each aspect of their lives. Analysis of the data was completed by calculating a numerical vote for each key issue followed by re-normalisation of each issue relative to the highest-ranked issue. Final comments and suggestions for further research were collated for each issue. Focus has been placed on the top-ten of these issues in Chapter 6 of this thesis.

In each round detailed written instructions were given to the expert participants regarding the Delphi process and how to complete the iteration. At the completion of the study a letter of thanks was sent to each participant and a report on the process of

the study as well the key issues identified in their professional and non-professional lives (Appendix 11).

# Section 3

## 5.3 The Semi-structured Interviews

### 5.3.1 Semi-structured Face-to-Face Interviews

The technique of interviewing has been likened to having a conversation with an individual who reveals their private experiences, perceptions of self, life and interpretations of social reality that they hold (Minichiello et al. 1995, p. 60). The common elements defining interviewing are

> ...a face to face verbal interchange in which one person, the interviewer, attempts to elicit information or expression of opinion or belief from another person or persons (Minichiello et al. 1995, p. 62).

Rice and Ezzy (1999) included semi-structured interviews in their description of in-depth interviews and in-depth interviews are variously described as focussed interviews, unstructured interviews, non-directive interviews, open-ended interviews and active interviews:

> These terms can be used interchangeably to mean the same thing. Semi-structured, or focused interviews sit somewhere between the fixed questions and forced responses of surveys and the open-ended and exploratory unstructured interviews with no fixed interview schedule (Rice and Ezzy 1999, p. 52).

Although the interviews described in this thesis were semi-structured, the process of conducting the study had similarities with a step-by step process for conducting a long interview. The long interview has been described as a qualitative approach that generates narrative and is described as holding distinct potential for primary health care (Crabtree and Miller 1991, p. 145). The goal of such interviews is to generate taped storied derived from informants through several broad, open-ended questions and follow -up prompts. After an appropriate literature review and collation of statements of preconceived bias of the researchers, the questions and prompts are developed and taped. The narratives elicited in these interviews are then described and analysed (Crabtree and Miller 1991, p. 145).

Rice and Ezzy (1999) posit that narrative is defined in different ways depending on the subject of the study, the method and the purpose of the study. They cite earlier work supporting the contention that there is no rigid definition of a story. Some definitions are so broad that they include nearly everything while others are quite limited, focussing on one aspect of a narrative (Rice and Ezzy 1999, p. 123).

Various styles of analysis are used with narratives. For the long interview it has been proposed that selected utterances be identified and highlighted in the transcript,

observations made about these segments, and themes formulated. However any other analytical style could be used in the analysis of long interviews (Crabtree and Miller 1991, p. 146).

In the semi-structured interviews conducted in the present study the questions were directed by an interview guide (Appendix 12), prompts were used, the transcripts taped and analysis followed. This process was preceded by the identification of researcher bias and accompanied by an ongoing literature review. Iterative thematic analysis was chosen as being best suited to working through the data in an iterative and sequential way, thus allowing the greatest chance of discovering the meaning and significance of the words and statements of the interviewees.

### 5.3.2 The Objectives of the Semi-structured Interviews

The objectives of the interviews were:

- To identify the key issues in the professional and non-professional lives of WGPs in Australia and how these are being considered by professional organisations and Colleges.
- To analyse the discourse and knowledge used in professional organisations and Colleges in identifying and tracking these key issues.
- To identify strategies that will address these key issues.

### 5.3.3 Procedure for the Interviews

The plan used to conduct the semi-structured interviews were similar to those used for conducting a long interview (Crabtree and Miller 1991, p. 146), these authors suggesting that interviews should incorporate a review of the literature (reviewing analytical categories), an inventory of the researcher's implicit categories and preconceptions (reviewing cultural categories), data collection (questionnaire construction, sampling, interviewing and transcription) and discovery of analytical categories (data analysis) (Crabtree and Miller 1991, p. 146).

In the present study iterative thematic analysis was used to analyse the data collected from the interviews. Reviewing analytical categories in this study were achieved through conducting a literature review and a review of sociological theory in tandem with reviewing historical material appropriate to the research, and by revisiting the key outcomes and issues raised in the professional and non-professional lives of WGPs raised in the Delphi Study. Cultural categories were reviewed by the investigator's self-reflection to determine her preconceived views and potential biases. The process of self-reflection is detailed in the section on reflexivity in this chapter. Self-reflection is an essential process since existing bias and preconceived ideas could influence the interpretation of the responses from the interviewees.

Discovering cultural categories was achieved by reviewing the design of the interview guide, sampling, collection and transcription of the interviews. Reviewing the interview guide determined which questions would best elicit information from

the participants on the issues under investigation. The interviews were held at various geographic locations in Queensland, New South Wales, the Australian Capital Territory, Tasmania, Victoria and Western Australia. Participants from South Australia were interviewed when they visited other States.

### 5.3.3.1 The Interview Guide

The interview guide (Appendix 12) consisted of seven open-ended questions. Four of the questions were designed to elicit responses concerning the key issues for WGPs, the identification and consideration of these issues by professional organisations and Colleges, why this was so, and how these issues could be tackled and addressed.

To begin the interviews, the interviewees were asked to outline their affiliations to professional organisations and Colleges and the roles they played in those organisations. The purpose of these questions was to gather information on the professional positions and status of the participants prior to leading them to tell their own stories relating to their experiences and perceptions of these organisations. The interviewees were also asked what they thought were the key issues for WGPs and how professional organisations and Colleges were addressing these issues.

The remaining question sought identification of other individuals who might be interviewed in the study. Planned prompts (referred to as probes by Crabtree and Miller) were included in the questionnaire to fill in the gaps when specific details

were missing or not completely elucidated (Crabtree and Miller 1991, p. 146). The prompts were only used to clarify the meaning of key terms and issues or to elicit depth and richness in the responses of the interviewees. The interview was designed to last approximately one hour but some interviewees took longer as the participants elaborated upon their experiences or provided more detailed responses.

Prior to the interview each interviewee completed a questionnaire that provided demographic information. The responses provided to this demographic questionnaire and the replies to the first two questions in the interview provided context to the interview and set the scene for the respondents' statements as the interview progressed. The interview guide was pre-tested prior to commencing the interviews by asking GPs and professional colleagues to answer the questions in an interview situation. This enabled modifications to be made to the guide and allowed the interviewer the opportunity to improve her technique by reducing intrusiveness and eliminating distractions.

Key features of the interviews were the building of rapport with the interviewees and being able to listen to the participant while facilitating free-flowing discourse, so that the participants were comfortable and felt that their contributions were of importance to the research. Glesne and Peshkin (1992) defined rapport as the

> ...relation characterised by harmony, conformity, accord, or affinity. Rapport is a distance-reducing, anxiety-quietening, trust-building mechanism that primarily serves the interest of the

> researcher. The ideal of rapport is developing sufficient trust for the conduct of good study...In the end, you will know when you have established rapport, because you will see it in the willingness of others to allow access to that part of their life of interest to you (Glesne and Peshkin 1992, pp. 93-96).

### 5.3.3.2 Sampling

The selection of interviewees for a qualitative investigation is "not a random or probability sample of biostatistics; rather it is a purposive sample directed by the research question" (Crabtree and Miller 1991, p. 148). Whereas quantitative research is concerned with probabilities and the distribution of experiences of individuals or processes, purposive sampling in qualitative research aims to "select information-rich cases for in-depth study to examine meanings, interpretations, processes and theory" (Rice and Ezzy 1999 p. 43). Purposive sampling is not concerned with ensuring that findings can be statistically generalised to the whole population, but rather draws its power and logic from the quality of information drawn for an individual interviewee. According to Berg "when developing a purposive sample, researchers use their special knowledge or expertise about some group to select subjects who represent this population" (Berg 2006, p. 44). In determining a sample for the semi-structured interviews, the researcher, as President Elect of the RACGP, had special knowledge and expertise of the general practice population in Australia and the professional organisations and Colleges concerned with General Practice. It was not difficult for her to access formal and informal networks of General Practice to identify GPs who had diverse background

experience in General Practice or who held prominent senior positions in national and state professional organisations and Colleges.

There are a number of different methods of purposive sampling in qualitative research, two of which (maximum variation sampling and snowballing) had application in selecting a sample for the semi-structured interviews. In maximum-variation sampling the researcher carefully selects "those cases that provide for wide variation in the experience or process being examined" (Rice and Ezzy 1999, p. 44). In this study maximum-variation sampling was used to select cases of GPs who were widely known to have considerable experience in General Practice and in the organisations and Colleges that were concerned with General Practice. A letter of invitation was sent to potential GP participants, a copy of which is found in Appendix 13. There was no difficulty or delay is in receiving 25 positive responses from GPs who were agreeable to become interviewees in the semi-structured interviews.

Snowballing is a method of sampling where one participant suggests the consideration of another. Provision had been made for snowballing to be used as an additional method of sampling if necessary by asking GPs at the time of interview the question, "Can you suggest anyone who could assist me with this research?" (see Appendix 12). It was not necessary or possible to use all the candidates suggested.

Ten males and fifteen females were invited to participate in the semi-structured interviews. The criterion used to decide the number of 25 participants was taken

from Seidman's definition of sufficiency and saturation of information. Sufficiency occurs when there are sufficient numbers to reflect the range of participants that make up the population, so that others outside the sample might feel connected to the experiences of those in it. Saturation is the point in a study where the interviewer is hearing the same information repeated and there is no longer anything new being revealed (Seidman 1998, p. 46).

### 5.3.3.3 Demographics of the Interview Participants

The median age of the 25 interviewees was 46 years (range 30-60 years). Apart from English, one interviewee spoke Greek, one Latvian, one Spanish and one German. Three were born outside Australia, one in Greece, one in the UK and one in Austria. All of the remaining interviewees were born in Australia. All interviewees had a Bachelor of Medicine and Bachelor of Surgery (MBBS), one received in London and the remainder from Australian universities.

The interviewees held a variety of other degrees and diplomas. Seventeen held the FRACGP, six held a Diploma of the Royal Australasian College of Obstetrics and Gynaecology, two a Doctor of Philosophy, two a Graduate Diploma of Clinical Education, and single individuals held a Masters of Business Administration, a Fellowship of the Royal Australian and New Zealand College of Psychiatry, a Masters of Rural Health, a Bachelor of Commerce, and a Masters of Social Science.

All but two interviewees were vocationally registered as GPs and all but two were

working as a GP at the time of the study. Seven were GPs from rural locations. Twenty four of the interviewees belonged to the RACGP, 17 to the AMA, 12 to a Division of General Practice, five to the RDAA, two to the AAAGP and three to the AAGP. Five had academic appointments with Universities.

The interviewees had held numerous prestigious positions in Colleges and professional organisations, and at the time of the study all held leadership roles, some in more than one professional or educational organisation or College. Key positions held by the participants included College Presidents (four), Vice Presidents (two), President Elect (two), secretaries of organisations, directors of education and training in General Practice, medical educators and examiners, a Deputy Chancellor of a University, a Censor in Chief, a Secretary General, a director of rural training and a director of training in Aboriginal health. Also represented was a member of a State Government Health Board, senior lecturers in General Practice (including rural General Practice), members of councils and committees, and chairpersons of national and State professional organisations and committees concerned with General Practice in Australia. Collectively they held extensive knowledge on the policies and politics of State and Federal government relating to the operation of General Practice in Australia.

#### 5.3.3.4 Interview Process and Ethics

Each of the potential participants in the investigation was sent a letter explaining the purpose of the research, the research process and an invitation to be interviewed by

the chief investigator (see Appendix 13). In addition they were sent a copy of the outcomes from the Delphi Study. They were asked for their personal views and experiences rather than the official policy of any organisation or College to which they might belong. When the potential participant responded positively by either e-mail, fax, phone or post, a date and location was set for the chief investigator to travel to an agreed location to conduct the interview.

There were no gatekeepers to prevent access by the investigator to the participants and none of those approached to take part in the process refused. All participants completed the interview process and each interviewee was sent a letter of thanks for their involvement in the study and the final transcript of their transcribed interview to read and comment on (Appendix 14).

Prior to starting the interview each of the participants gave their informed consent in writing. The requirement that informed consent imposes can be broadly interpreted as implying

> ...a responsibility to explain as fully as possible, and in terms meaningful to the participants, what the research is about, who is undertaking it and financing it, why it is being undertaken and how it is to be disseminated (Rice and Ezzy 1999, p. 41).

Participants who took part in the interviews were informed that clearance had been given to the project by the Royal Australian College of General Practitioners Research and Evaluation Ethics Committee. They were also informed that the

interviews would be audio-taped, and that confidentiality would be maintained, that the outcomes from the study would be in the form of de-identified data so that participants remained anonymous, and that they had the right to withdraw from the study at any time.

Before the interview commenced each participant was provided a protocol explaining the purpose and process of the study (Appendix 15), a copy of the key outcomes of the Delphi study, a copy of the questions for the interview, a form for suggested names of other possible interviewees and a form (with a code number) to record their demographic details.

Since all interviews were audio-taped the participants were asked for their verbal consent prior to the tape being started. They were told they could request that the tape be turned off at any time. At the request of one interviewee the tape recorder was turned off during a short section of the interview during which time the interviewer made detailed field notes. These notes taken were later used to add context to the interview. Field notes also recorded body language, non-verbal cues and notable features of the interview setting. Verbatim transcription was made of each taped interview. Pauses, laughter, delays, periods of silence and other obvious displays of emotion were also transcribed.

A code number was attached to each participant's tape and transcript so that identity of the participant was not subsequently revealed. Any names, personally identifying

material, or locations were removed from the transcripts and all transcripts and tapes were kept in a locked container.

#### 5.3.3.5 Advantages and Limitations of Interviews

The advantages and limitations of the semi-structured interviews undertaken in this study are akin to those described by Rice and Ezzy (1999) for in-depth interviews. Such interviews allow the discovery of the subjective meaning and interpretations that people give their experiences. They enable aspects of social life and social processes to be studied that could not be studied in any other way. Subsequently, new understandings and theories can be developed during the research process. The participants' responses to questions are less influenced than they would otherwise be by the presence of peers during interviews. By telling their story the interviewees can gain new insights.

In the case of the interviews conducted as part of this research, the interviewees generally found the experience rewarding, since it allowed them to review the key issues in the lives of WGPs and their expectations and concepts of organisations and colleges concerned with General Practice. On the negative side, the interview methodology was expensive and the transcribing of tapes and data analysis required dedication and time to accurately elicit meaning. This author can attest to the conclusion that in-depth interviewing "requires persistence, and sensitivities to the complexities of interpersonal interactions" (Rice and Ezzy 1999, p. 68).

### 5.3.3.6 Analysis of the Interviews

Rice and Ezzy describe themes as important messages that emerge from the material under examination and these themes are the categories of the analysis (Rice and Ezzy 1999, p. 106). Iterative thematic analysis was selected for the 25 interviews forming this study. Seidman (1998) explains that excerpts taken from transcripts are organised into categories. Connecting patterns and threads among those categories and between the various categories are located and these contribute to "themes". Themes are organised so that excerpts from the transcripts can be used to support and demonstrate the themes as the study report is written. In considering the strength of in-depth interviewing as a methodology Seidman (1998) says that

> ...through it we can come to understand the details of people's experience from their point of view. We can see how their individual experiences interact with powerful, social and organisational forces that pervade the context in which they live and work (Seidman 1998, p.112).

Hansen notes that "researchers conducting iterative thematic analysis use a variety of techniques to identify 'interesting' sections in the data" (Hansen 2006, p. 139). In the first stage of analysis in this study interesting passages of transcripts were marked, labelled and put into computer files that represented a particular category. This process constituted the "classifying" or "coding" of data. The blending of categories (developed during the process of coding) and the retrieval or disposal of other proposed categories took place at a later stage. A notation that designated

which interview, and from what page of the interview, the passage had been taken was attached to each marked passage, this allowing quick reference to the original transcript for review of content, context, or accuracy.

The passages of transcript placed in computer files within a previously labelled category were read within that labelled category so that a process of sorting and culling could take place. Some passages were of prime importance and retained, some were of less interest or importance and set aside. This process was repeated until the investigator felt satisfied that there was a connection between the passages within each file and that the name of the file was appropriate to the central idea or ideas expressed by the passages contained within each file. The categories were then reviewed, connecting patterns sought and themes developed. A copy of the initial coding framework is found in Appendix 16.

The iterative process of testing the themes with the data, working with excerpts from the participants' interviews, seeking connection between them, explaining those connections and building interpretive categories was challenging and rewarding. Patience, perseverance and becoming immersed in the data produced the best outcome from the analysis. The process enabled the data to be connected into a final framework (Appendix 1) which is referred to in subsequent chapters in this thesis. Sharing the stories of the participants was a responsibility and a privilege. Quotes from the interviewees' responses supported the themes in the written report in this thesis.

**5.3.3.7 Triangulation**

Rigour in research is enhanced by triangulation of data sources, methods, researchers and theories. Triangulation enables the development of a complex picture of the phenomenon being studied, which may not be available if only one method is used. Triangulation has been defined as the use of multiple methods which "involves a combination of methods, researchers, data source and theories in a research project" (Rice and Ezzy 1999, pp. 35-38.).

Three types of Triangulation have been utilised in this study; Data Source Triangulation, in which multiple information sources are used, Methods Triangulation in which multiple research methodologies are used, and Theory Triangulation in which multiple theoretical perspectives are used to provide new insights.

In the present investigation data source triangulation was achieved by the use of a reference group, the Delphi study, male and female interviewees in semi-structured interviews, all combined with history and sociological theory and an extensive review of the literature. Using a multi-strategy approach in this research contributes to triangulation which facilitates cross-checks on the validity of findings and concepts that emerge from the data analysis.

Method triangulation was achieved by the use of two different methodologies (the Delphi study and the semi-structured interviews) to support each other. The use of

pre-determined criteria in selecting the participants for the Delphi Study and the use of maximum variation sampling (with the provision of snowballing) in the semi-structured interviews further assisted the triangulation process. As is evident in Chapter 4 of this thesis Theoretical triangulation was also met by the use of multiple theoretical perspectives.

#### 5.3.3.8 Validity and Reliability

In quantitative research the standards most frequently used to determine good and convincing research are validity and reliability. Valid research closely reflects the world being described and reliable research implies that two researchers studying the same area will produce compatible observations. However Rubin and Rubin (1995) claim that most indicators of validity and reliability do not fit well with these notions, and this distracts from qualitative research. Instead they claim:

> Researchers judge the credibility of qualitative work by its transparency, consistency, coherence, and communicability; they design the interviewing to achieve these standards (Rubin and Rubin 1995, p. 85).

Rice and Ezzy (1999) posit that concepts of validity and reliability raise issues that need to be addressed by qualitative researchers. They argue that rigour refers to the issues that are raised by the terms validity and reliability and they are conceptualised differently. Rigorous qualitative studies are more trustworthy and useful than others. At the centre of the problem with the concepts of validity and reliability in

qualitative research is the relationship between the observer and the observed reality (Rice and Ezzy 1999, p. 31.).

### 5.3.3.9 Transparency

Transparency means that the processes of data collection are visible to the reader; a transparent report allows the reader to assess the intellectual strengths and weaknesses, the biases and the conscientiousness of the interviewer (Rubin and Rubin, 1995, p. 85). The interviewer must be vigilant in maintaining records of what was seen and done, and make the research transparent to others.

To ensure transparency in thesis investigation, original records, tapes and transcripts were accessible for review. In addition written transcripts were verified by the interviewees and records were kept of the organisation and analytical processes used. All editing was recorded on copies of the original transcript and a workbook kept on the research process and how the investigator felt about it. This record provided a summary of what the investigator had seen and learned and the investigator's thoughts on the subject at that time. This process allowed the investigator to have a strong connection with the outcome of the study.

### 5.3.3.10 Consistency

As part of undertaking credible research interviews, the researcher must check responses that appear to be inconsistent. When themes are coherent, explanations

can be given as to why apparent contradictions occur and what these contradictions mean. When the interviewees report inconsistent views an explanation of why this occurred should be sought so that the research is seen as credible. If this is done the reader is more likely to believe that the interviewees are responding openly and the researcher has sought out the richness in the interviewees' answers.

Credibility is also increased when core concepts and themes recur in different cases and settings. Themes that do not occur must be revisited to explore the circumstance under which these themes hold. In the present research study the iterative process of thematic analysis highlighted recurrent themes in different settings and occasions where there were inconsistent views form the participants and contradictions of core concepts. The consistency and inconsistency of themes that occur is demonstrated in Chapter 7 where the themes from the semi-structured interviews are tested with the data. Through this process the core requirements of consistency are met.

**5.3.3.11 Communicability**

The area under investigation should always appear to be *bona fide* to the participants and readers and other researchers should be able to understand and accept the outcomes because they complement existing experience or literature. Richness of detail, a wealth of evidence and clarity and detail of the text helps provide authenticity. The interviewees must report their own experiences rather than the experience or views of others. Careful documentation of consistent and coherent material is convincing and credible.

The current interview study demonstrated the value of iterative testing of concepts and themes which maintained the credibility of the research and built a consistent portrait of the opinions of the interviewees, satisfying the criteria for credibility. Generous quotes from the interview transcripts supported key conclusions drawn from the investigation, culminating in the synthesis reported in Chapter 7.

## 5.4 Conclusion

This Chapter describes how the key issues in the lives of WGPs in Australia and the socio-political space they occupy in the organisations and Colleges concerned with General Practice were investigated using qualitative methodology. The reasons for selecting qualitative methodology are explained and a description is provided of how the Delphi technique and the semi-structured interviews were undertaken in this thesis. The demographic data of study participants is also reported.

The Delphi technique was used to articulate key issues in the professional and non-professional lives of WGPs. A national group of WGPs who acted as a reference group provided wise counsel throughout the study. The expert participants in the study referred to their own experiences to provide suggestions on how to further investigate or address the outcomes from the study. The most important ten key issues of the professional and non-professional lives of WGPs in Australia were listed in rank order as reported in Chapter 6.

Semi-structured face-to-face interviews with both male and female GP participants were used to investigate the key problems affecting WGPs in Australia, and possible ways of ameliorating the inequities that exist, in current General Practices and organisations and Colleges. All of the interviewees were occupants of senior professional positions in Australia and their expertise contributed to the study outcomes. The analysis of the discourse and knowledge used by professional organisations and Colleges identified the socio-political space WGPs occupied in General Practice, organisations and Colleges and suggested strategies to address the key issues for WGPs in Australia. The next Chapter in this thesis details the consensus reached in the Delphi study by the WGP participants regarding the key issues in their professional and non-professional lives.

# Chapter 6

# Results of the Delphi Study

## 6.0 Introduction

This Chapter reports the consensus reached by 39 WGPs who completed a Delphi Study regarding the key issues in their professional and non-professional lives. It also reports possible strategies that the WGPs suggested to address the concerns identified in the Study. The Delphi Study was conducted from October 1996 to January 1997 and the participant WGPs were drawn from all Australian States and Territories. Details of the methodology used for the Delphi Study and the demographic profile of the participants are discussed in Chapter 5. After three iterations of the Delphi process, consensus was reached by the study-participants on the key issues affecting their professional and non-professional lives. In the third iteration each participant gave a final vote for each of the key issues. This allowed for a collective ranking of the importance of the key issues from the number of votes each issue received. A publication from the Delphi Study (Kilmartin et al. 2002) is given in Appendix 17.

## 6.1 Ten Key Issues in the Professional Lives of Women General Practitioners in Australia (in rank order)[1]

| Key Issue | Relative Score |
|---|---|
| Achieving job satisfaction in General Practice through mental stimulation, challenge, and a variety of work. | 1.00 |
| Balancing professional and non-professional life by drawing boundaries to protect oneself, family and interests. | 0.52 |
| Management of time to allow for successful participation in all aspects of professional and non-professional life. | 0.50 |
| Having a strong sense of self-esteem and self-image, leading to autonomy and control over professional life. | 0.46 |
| Having the option of flexible hours and part-time work to allow fulfilment of multiple non-professional roles. | 0.40 |
| Having sufficient income to cover professional expenses and to provide for financial security. | 0.34 |
| Receiving fair remuneration for medical services and work performed. | 0.31 |
| Juggling the complexities of competing priorities in one's professional life. | 0.29 |
| Having the ability to train and retrain (after time out of the workforce) in a flexible part-time training program that caters for the individual needs of women general practitioners. | 0.29 |
| Having a voice and share of power in decision-making about issues affecting women GPs. | 0.26 |

[1]The ten key issues emerging after three iterations were separately scored by the 39 Delphi participants, with a score of ten being given to the highest-ranked issue, reducing to a score of one for the lowest-ranked issue. The relative merit of each issue was then ranked against the highest-scoring issue (given an arbitrary score of 1.00).

## 6.2 Ten Key Issues in the Non-Professional Lives of Women General Practitioners in Australia (in rank order)[1]

| Key Issue | Relative Score |
|---|---|
| Making time for self-care to avoid stress, guilt, "burn out" and mental ill-health. | 1.00 |
| Having time to nurture a quality relationship with a partner. | 0.77 |
| Having the time to spend with children to take care of them and to share life experiences. | 0.64 |
| Managing time to allow for successful participation in all aspects of professional and non-professional life. | 0.61 |
| Having time and ability to engage in social contacts and foster friendships. | 0.48 |
| Finding a balance between one's career and that of your partner. | 0.44 |
| Providing a focus for family life and all the requirements and activities of the family. | 0.42 |
| Having time for non-medical interests that allow for a range of life experiences. | 0.31 |
| Having sufficient income to pay for private expenses, such as child-care, mortgages and personal requirements. | 0.28 |
| Balancing professional and non-professional life by drawing boundaries to protect oneself, family and interests. | 0.26 |

[1]The same system of ranking was used as described above (6.1).

From the tables above it is evident that little separated the bottom four ranked issues in the professional lives of the participants or the bottom three ranked issues in their non-professional lives, whereas the most important single issues was clear-cut in both cases, respectively being achieving job satisfaction and making time for self-care.

## 6.3 Job Satisfaction

Achieving job satisfaction was a clear priority for the WGPs in their professional lives and most of them wanted work that embraced a broad range of problems and patients. They claimed that this provided mental stimulation, challenge, enjoyment, variety and an incentive to work. As one WGP said:

> One must enjoy work in order to achieve maximum satisfaction. One must also find a job and environment that fulfils this for each woman otherwise the incentive to work is lost. This is why we work at all.

Although job satisfaction was seen as important, another participant thought that the vocation of medicine surpassed this, saying "Job satisfaction is important, but the vocation of medicine more so. This is why I do General Practice".

Variety of work was perceived as being essential for job satisfaction and "this was not achieved by being limited to women's health or by doing General Practice alone" wrote one participant. Some of the women described how they intended to achieve a broader range of work, with one WGP planning to practice in a remote location and develop a

special interest in musculoskeletal medicine:

> I don't know how it can become so GPs don't just do women's health. My response has been to go remote and do a diploma in musculoskeletal medicine, so when I go to the city I hope to attract a broader range of patients, not just gynae, antenatal and emotional problems.

The reason for becoming a rural practitioner and working in a remote location given by another WGP was that she achieved more satisfaction than she did when working in the city.

A link was identified between working part-time and the ability to pursue other interests or develop skills in a sub-speciality. According to one WGP:

> I am beginning to believe that I could not achieve satisfaction through General Practice without developing a sub-specialty or working part-time and pursuing other interests.

The tendency for GPs to become referral agents was a concern for the WGPs, and it was suggested by one that this could be avoided by equipping GPs with increased skills. In her words, "Re-skilling or resisting deskilling is needed to prevent General Practice becoming a referral agency for other specialties". An urban WGP felt that the loss of skills and procedures for the profession challenged her desire to be a "real doctor" but that the job of her husband had restricted her to working in an urban practice location. She declared:

> When I finished medical school I wanted to be a real doctor i.e. do everything. It would seem one's only opportunity to do this would be in a rural area in Australia. For me with a husband in State Government bureaucracy this is impossible, too bad. Our profession is shrinking in terms of skills and procedures, especially in urban areas.

A range of strategies were suggested by the WGPs to improve job satisfaction including:

- Undertaking research (especially rural research) to address specific issues.
- Providing support by WGPs mentoring medical students and registrars in General Practice.
- Conducting focus groups and questionnaires for WGPs in rural, remote and tropical areas, including different age groups, non-English speaking background women and GP registrars in the RACGP Training Program.
- Providing flexible training options.

## 6.4 Balancing Professional and Non-Professional Life

Balaucing ones professional and non-professional life was rated as the second key issue in the professional lives of WGPs and the tenth key issue in their non-professional lives. The issue of balance also arose in relation to their individual careers and those of their partners. Participants spoke of the importance of achieving balance for their mental health, self-care, well-being and in their relationships with their partners and families. A WGP concluded that, "I see this covering all the major

important areas, self, partner, family and professional life".

One WGP summed up the importance of achieving balance as follows:

> After all, it is only when we are mentally healthy that we can properly function as doctors and people. Anyone who does not do this will have problems. Family and personal life must be intact so you can practice as a good GP. Patients will find another doctor if you become sick and will forget about you quick.

Another participant admitted that "a major downfall in her professional-life had been lack of self-care" and that finding and maintaining balance was "...a life skill that everybody, not just GPs, need to learn; although it is vital to mental well-being, it is not always easy to achieve". Learning the skills to achieve balance involves the drawing of boundaries and setting of limits and priorities to protect oneself, family and interests, explained a WGP:

> It includes saying no to demands by the practice and patients, (e.g. social consultations) and being strong in setting limits. Some patients don't realise that you have a life outside work and that family comes first.

One WGP drew boundaries by involving the family in a series of white lies, ones that her children had also learned to tell, for example "Mum's on a house call". Another respondent opined that WGPs carried a heavier load of professional and non-professional responsibilities than men:

> The dilemma of organising one's personal life with its relationships, marriage, children, housework and professional obligation is more of a problem for women. Women doctors' commitments remain heavier than men.

Consequently coping with guilt was a problem for WGPs and as one WGP lamented "This balancing act makes one constantly feel guilty about something. There are lots of guilt issues related to these choices that need to be made".

Some GPs may want to provide an extended system of on-call and spend long hours at work but one WGP felt that this detracted from job satisfaction:

> One of the main reasons for choosing General Practice is the lack of private patients entitled to call you 24 hours a day, seven days a week. If some GPs want to be available all this time that is their problem.

The God-like behaviour of doctors who find it difficult to share patient care was challenged by a WGP:

> It takes time to learn that your patients will survive without you and you are not God-like. It takes a lot of time and change over the years to acknowledge this.

Redefinition of what a family doctor should be in contemporary Australia was the suggestion of one woman who asked: "Why should GPs feel that they have to be all things to all patients? Perhaps we need to redefine what a family doctor should be in

contemporary Australia".

It is difficult for doctors who are located in remote areas to achieve balance in their professional and non-professional lives. A WGP found that

> ...this is the hardest of all, especially when you are the only doctor in the community. It is hard to switch off especially when on call, which I am for approximately 140 hours a week.

The same WGP found that attending workshops and receiving counselling on conflict resolution, self assertion and stress management had helped strengthen her boundaries and keep balance, despite this being difficult to achieve in a small single doctor remote community. The WGPs taking part in the Delphi Study suggested that conducting discussion groups and seminars may provide solutions to maintaining balance in their lives.

## 6.5 Finding Balance Between One's Career and the Career of a Partner

Finding balance between one's career and that of one's partner was, according to a WGP, a problem that "needs a great deal of flexibility and may limit one's options; however neither should have to sacrifice their career". The solution to this she said lay in "the basics of marriage, that each will consider the other". This issue was also seen as not specific to WGPs, and was said by another WGP to be "devastating if it can't be settled". This participant explained that in her case "we are both working professionals so we constantly juggle".

A respondent admitted that inability to find career balance between herself and her partner had been an "ongoing source of fights in my marriage". However, for other women the outcome was more satisfactory, one WGP saying "My husband is a general practitioner so we don't have a conflict of interests".

It was reported by one of the WGPs that "in the training program most female GP registrars let their partner's career take precedence". The view of another WGP was however quite the opposite:

> Just because a partner is a specialist and has a "Y" chromosome doesn't mean his career is more important. Some partners can't cope with successful wives. However, it does seem easier for GPs to make sacrifices and changes and it is more flexible and easier to leave and relocate.

Working in a rural setting made this issue particularly significant for participants. According to a WGP:

> Especially in a remote area where employment opportunities are few for partners; there needs to be ongoing support to rural partners. Support often favours women-partners.

It was difficult for women to find a balance between their own career and that of a partner when it came to "going overseas for further experience or moving for rural terms". This is "a very personal situation and will be handled differently by different women" said one WGP. A satisfactory balance was found by one participant, who

said that

> ...while home having children my partner's career has become more of a priority at present. Later on I feel this will equalise as I can make more money. My partner is a very sensible man.

The challenge for single WGPs was "to find a partner first" and until that happened career balance was not an issue. One of the WGPs thought; "It would be useful to undertake research to see if it makes any difference being married to a non-medical or a medical partner".

## 6.6 Management of Time

The issue of time management was a dominant theme in the Delphi Study, it rating in the top ten key issues of both the professional and non-professional lives of WGPs. Time management was pivotal to the WGPs' relationships with their partners, children, social contacts and friends and also governed the provision of self-care, and the fostering of non-medical interests.

According to one of the participants the organisation and management of time for WGPs to participate in all aspects of professional and non-professional life proved to be "our greatest difficulty as women GPs and the greatest problem facing me". This issue was describes as an "...individual thing appropriate to everyone. It probably needs to be worked out on an individual basis with employees, partners and family.

Time taken to write legal reports and insurance reports should also be recognised as part of our work load".

One WGP acknowledge that there was "access to credible time management schemes" but time management was

> ...often thrown out by sick children and emergencies at work. It was difficult to take a day off if a child gets sick when I have an important clinic and work commitments.

Other comments on this topic included:

- "Time management is a difficult jugging act and I wish I were organised."
- "Professional women with children must have good organising skills. I find this hard. I feel that I am always clock-watching to try to get everything done."
- "Acquiring the skill necessary for time management is part of postgraduate training where people can be taught to use time more efficiently. Time management is the key. It is important to value that we are whole people and we need to acknowledge our whole-person-ness."

Strategies to achieve suitable time management suggested by the WGPs included working flexible hours so that they are able to share work, do part-time work and conduct research in working hours. It was also suggested that time management training for WGPs and family members and the placement of

more rural GPs to spread the workload in rural areas would be of benefit to WGPs.

## 6.7 Time for Self-Care

Making time for self-care to avoid stress, guilt, "burn out" and mental ill-health was rated as the greatest priority for WGPs in their non-professional lives. The participants said that they did not identify stressors in their lives sufficiently early to allow for self-care. According to one, "This seems to be part of living in the late 20th Century information- and expectation explosion".

Some participants admitted that they had been driven to "breaking point" as a result of not taking time for self-care. One of the women explained that she had she had "changed positions three times as I have been unable to protect myself from burnout; time for self-care was never acknowledged".

Another WGP reported "...all of this has happened to me. I do not want it to happen again. I came close to breaking down earlier this year". The participants in the study agreed that they recognised the importance of self-care but found it difficult to make time to carry it out. "I am afraid to admit I don't have any time for myself. This is very important but it is almost impossible to make time for myself", said one.

Reasons given by the WGPs as to why time was not available for self-care were:

- Problems with demanding partners, which one WGP explained as being "hard because my husband is unemployed and wants my attention when I get home".
- Problems with postnatal depression.
- Problems with stress at the surgery, one WGP saying "it is difficult to not become stressed because the surgery is a very high stress environment".
- Problems with the effect of cumulative pressure at home and in the surgery.

The WGPs realised the value and importance of self-care but some felt guilt when taking the time to achieve it. As one respondent said:

> I need self-care so I am able to be an interesting good wife and mother. This has always come first for me and probably always will but I almost start to feel selfish when reading others' comments.

Another WGP believed that taking time for self-care was a quality of life issue:

> Medicine may be a vocation but it is your life to be lived. This is the context of my priorities, myself, my partner, my children, my career. Above all maintain your own sanity and look after number one whatever it takes, otherwise there will be no quality to your life or relationship with family, friends or patients.

When "family commitments begin the children need parent's time", but this did not negate the importance of self-care:

> This is my key personal issue. Making time for self-care to avoid stress, guilt, burn-out and to protect physical and mental health.

Strategies suggested by the WGPs to achieve self-care included:

- Providing training and lectures on self-care for medical undergraduates, registrars in the RACGP Training Program and GPs through PD activities.
- Providing workshops on time management, stress management and the importance of "doctors having their own GP".
- Having WGPs mentors who provide advice, support and discussion on the question of: "Why do doctors feel they have to be invincible?"

## 6.8 Time to Nurture a Quality Relationship with a Partner

Having time to nurture a quality relationship with a partner was ranked second of the key issues in the non-professional lives of WGPs. In the words of one WGP, having a quality relationship with a partner was "vital to my self-esteem and an important issue that was neglected, as work tends to overtake my private life at times".

Another WGP identified that having children, her partner's job and her professional career were barriers to a quality relationship and having more time available was not necessarily the answer:

> Children rather than work are the barrier and nurturing a quality

> relationship with a partner (who often has a professional job) is difficult when one is caught up with work and education.

Working part-time enabled one WGP to enjoy a quality relationship with her partner:

> My current relationship with my partner is arguably the only quality relationship with a partner that I've had. It began as soon as I started to work part-time. I used to feel that my work was more important than any relationship. This never brought me any joy.

A WGP felt that nurturing a quality relationship was a personal responsibility and she acknowledged that this was her "least successful issue [but] it is my responsibility, and has little to do with being a GP". Conversely another WGP believed that nurturing a relationship was a responsibility shared by both the partners:

> I am very lucky as my partner is very understanding and does a lot to nurture our relationship. For me continuing to work part-time will be important to this end. Working full-time I just often didn't have the energy, feeling mental burn-out at the end of the day. I think a quality relationship can be nurtured even with just a little bit of time, if big issues are addressed and a partner understands your duties and responsibilities. The more time the better however.

Strategies suggested by the WGPs to address the issue of time to nurture a quality relationship with a partner included:

- The finding of female role models, so that WGPs can learn to understand the need to allow for individual time.
- Undertaking research on how female doctors working full-time sustain successful partnerships.
- Providing education concerning making a cultural change regarding work.

As one WGP said:

> This is a societal issue as well as an issue for WGPs. Education and training is needed by both male and female GPs regarding nurturing quality time for their partners. There needs to be cultural change so that it seems 'okay' not to be workaholic.

## 6.9 Time to Care for Children and to Share Their Life Experiences

This issue was ranked third in the non-professional lives of the WGPs. The WGPs participating in the Delphi Study agreed that an important factor in the management and organisation of their days was the need to allow sufficient time to keep in touch with children, to provide for them and share their life experiences.

One WGP thought that this was "something I am good at but I still get strained at times". Other participants felt that their children were only small for a brief period in life and they had needs that their mothers wanted to fulfil. This was emphasised in

comments such as:

> Children are little for such a short time and need me. They are only young once. Our input into these fragile little people is so important.

> My children are the most important part of my life. They need me more than my patients. I like to keep an active role in my children's growing up, their education and being there for them when needed. Make time! If I fail as a mother my hard won self-esteem would be rocketed.

It was acknowledged by the WGPs that this issue was not unique to female GPs. However, a question raised by one respondent was: "Why did we have children if we can't enjoy and nurture them?" It was thought that if there were a better understanding of the complexity and responsibilities of a mother by employers and partners in the workplace, this would help mothers who are trying to fulfil their roles of parenting as well as professionals. As one WGP said:

> This would be easier if we were not made to feel so guilty for not taking 5.30 p.m. appointments, or only doing mid-morning to mid-afternoon sessions, or not doing a house call between the end of a session and picking up infants from day-care. More understanding from employers and professional partners would be nice.

This understanding was also called for when children of the WGPs became ill. It was difficult said one WGP, "to take time off if a child is sick and one has important

functions and work commitments".

## 6.10 Time for Social Contacts and Friendships

Time to engage in social contacts and foster friendships was desired by the WGPs, but the reality of their finding time for this was difficult. Comments made by the participants regarding this issue included:

> "My friends have always been important to me. I still do not have enough time to spend with them."
>
> "I can't find time. Relationships and friends become much more important as one matures. Time is required to develop oneself as a person as well as a doctor."
>
> "Between work and my children my husband and I are losing contact with friends."
>
> "The girlfriend network is essential to me. My friends supply lots of support. Long hours at work have meant it is hard to have enough time for this."

One respondent noted the importance of friendships to her saying:

> A decline in social life is readily noticeable moving from the hospital environment to General Practice. Friendships are important to ground oneself in reality. Perhaps we could all go down to the pub to address this issue further.

On the other hand for some WGPs part-time work and having children provided the opportunity to make social contacts. According to one WGP:

> It is very important to keep touch with normality. One has to work hard to make time for this. It is easier to achieve when working part-time and when one has small children.

Another WGP found that as a single person she could more readily engage in social life but she said this had

> ...only occurred since my partner left. I can now spend time enjoying myself. I have found making regular 'dates' with friends the way to go. One needs to make priorities. Divisions of General Practice are a good way to combine education and socialising.

## 6.11 Having Time for Non-Medical Interests

A frequent explanation that WGPs gave for needing time for non-medical interests was that "There is life after medicine and other experiences are important". Taking part in non-medical interests allowed for a range of life experiences and one woman found that this was "...definitely more of an issue now we have children and I can't find the time". Other WGPs thought that one "has to get out of the medical world to appreciate the real world of patients". To achieve this "more flexibility with work life" was required as well as "better time management". One woman's strategy was

to "keep a family diary of events for the week and try to plan events involving the family for free weekends".

A WGP participant in the study felt unfulfilled by being a medical practitioner saying "I have to admit that medicine doesn't really fascinate me and I'd rather be on holiday or doing something different". Unfortunately the methodology of the Delphi Study did not allow for this important comment to be further explored.

## 6.12 Providing a Focus for Family Life

The WGPs agreed that their definition of 'family' included immediate and extended family members and that family life should involve quality and balance. According to one WGP:

> My family is very important to me and I find it necessary to spend quality time with them. The balance is very delicate.

That the responsibility for family rested with the mother was assumed by one WGP, while another WGP saw this as a shared responsibility saying, "It is not my role to do this. It is shared with a partner and as the children grow up with them too". Those participants who saw this issue as primarily their role found that making time for family life impacted upon them significantly. According to one woman:

> This is where I spend all my non-work time; it is difficult to spread myself, I am constantly juggling.

## 6.13 Juggling the Complexities of Competing Priorities in WGPs Professional and Non-Professional Lives

This issue was acknowledged by the WGPs to "apply to every working person and was not only a key issue for female GPs". One respondent explained that juggling was, "part of the time hurdle", saying:

> What comes first, patients, family or self? You can't keep everyone happy all of the time. One needs an understanding of social networks. Lack of government support for child-care is also unhelpful for all mothers.

Juggling complex and competing priorities was an issue for a WGP who had a "house-husband". Her friends and supporting network helped her deal with the priorities required to protect her from feeling guilty:

> I have a house-husband. When I finish work he wants my attention immediately. I want space. Friends have helped me step back from the situation and see that I shouldn't feel guilt about this and we can now talk and get a better compromise. I used to feel guilty that he was supporting me in my role (a job with long hours which I dearly love) and that I should give up my time out of work for him. It took a friend to point out that this was ridiculous and that he must allow me some space too and I don't need to feel guilty.

## 6.14 Receiving Fair Remuneration

Receiving fair remuneration for medical services rendered was a "very important" issue for the WGPs because said one participant "financial independence is important for all women". The remuneration that WGPs received was considered in relation to the nature of their work, the long consultations and the medical services that they provided to people in disadvantaged areas. One woman said there should be

> ...higher remuneration for General Practice work in comparison with procedural specialists. Our work is harder and more complex. We are definitely not getting fair remuneration for our quality care. Remuneration, monetary or otherwise, does not reflect stress of jobs and skills involved.

Another WGP extended this issue to include all GPs saying, "All general practitioners who practice good medicine are underpaid. WGPs' work is essential to the community but this sought-after work is not fairly remunerated".

The WGPs thought that their "style of practice reflects the personal needs and wants of males and females". One participant wrote:

> GP services are not fairly rebated. There needs to be research and lobbying for higher rebates for non-procedural and specialised areas e.g. counselling, non-patient contact work and recognition for extra training.

Research of the issue by "looking at Health Insurance Commission statistics of male versus female GPs" was suggested by a respondent who noted that "the nature of my practice profile makes this issue relevant and it should be looked at". She added that "Possibly this was truer for remote and rural women".

Strategies suggested by the WGPs to address the issue of receiving fair remuneration included the need to undertake research on relative male and female remuneration, and ensuring that there are WGPs on practice management committees of the RACGP and on national finance committees.

## 6.15 Having Sufficient Income to Pay Expenses and Provide Security

Having sufficient income to cover professional expenses and to provide for financial security was as a key issue in both the professional and non-professional lives of the WGPs. According to one WGP this issue was

> ...immensely important and essential. This is why I work to provide family security that is vital for my independence and important to the family unit. I contribute almost 50% of our household income.

Families, especially children were often the recipients of the financial benefits from the work of the WGPs and one sole parent found that, "With children there are more expenses but less time to work. Being a sole income earner with two children this is very important".

Another mother supported this contention by saying that "there should be value for the work put in and more remuneration for the difficult job that we do". The lack of income posed a significant concern for single women who were self-supporting and those senior WGPs for whom financial security was imperative. One participant wrote that "being single and supportive of myself, financial security for my old age is important".

Payment of "accessible affordable child-care for children" as well as providing shelter was a problem for many of the WGPs. A mother said that it was "not necessary to have private education but one must have some sort of roof and food". In addition this WGP felt that having a "reasonable and sufficient income provides good motivation to perform work" but there was a need for a fairer schedule of fees for GP services.

Those women who worked part-time found that

> ...it is difficult to balance working part-time with how much money was enough money. There was less financial security if you cannot be guaranteed regular income such as a percentage of Medicare rebates as payment for work performed. It is important to be paid what you are worth.

Another WGP who worked part-time commented on the high cost of medical subscriptions and the difficulty paying these from the income derived from part-time work:

> When working part-time much of your income goes to paying medical defence, registration, professional fees, College dues and education expenses. These are quite expensive.

Some WGPs were not affected to the same extent regarding receiving sufficient income. One WGP said she "was in a fortunate position in that her partner earns well" so she was not negatively affected by this issue. However, another WGP challenged the perception that the income of a doctor was substantial; "If incomes were higher, then a lot of the other issues would be easier to attain". Finding how to address this issue was important since it was "being discussed *ad nauseam* and definitely needs to be resolved; General Practice is being increasingly devalued not only in a monetary sense" added this WGP.

One WGP suggested that that this issue was "probably more of an issue for part-timers especially, if they are not vocationally registered". Attempting to become vocationally registered was not easy for some WGPs, one participant finding that she had "no problem with the examination but having to do five years full-time equivalent General Practice as well, especially after ten years in hospitals, aged care and obstetrics was hard".

## 6.16 Flexibility in Work Hours and Training Programs

The WGPs in the Delphi Study identified the need for flexibility in their work hours and the availability of part-time work to allow fulfilment of their multiple non-

professional roles. After time out of the workforce they also required flexibility to retrain in programs that cater for the individual needs of WGPs:

> Flexible work commitments are vital for family security although this is a personal choice. Many women doctors have heavy domestic commitments. They require support organising their working lives especially once your children start school. It is very hard to find the right schedule.

In a similar vein a WGP suggested that this issue can precipitate a situation where WGPs are significantly strained when trying to provide for children as well as others. This is "especially an issue with small children, if one is trying to be everything to everyone. Maybe we need to know it is okay not to be". The WGPs agreed on the importance and "availability of part-time work as General Practice is an ideal way to combine family and work and ways must be found to iron out any inequalities that arise from this".

There was concern voiced by the WGPs that part-time training may not be retained in the future:

> The Federal Department of Health and bureaucrats and the National Health Minister need to be lobbied vigorously to ensure that there is no further curtailment or cessation of part-time training. The bureaucrats are not supportive of it. The RACGP Training Program no longer has the capacity to provide retraining as in the early years so the RACGP may consider doing something.

The cost of education courses was a barrier for one WGP who said "When working part-time I can barely afford the cost for living and evening educational courses offered, yet I need to keep up". Working full-time would alleviate this problem said a WGP who claimed that this was "not an issue for full-time general practitioners and women should be prepared to work full-time". However another WGP asserted; "I disagree that women should be prepared to work full-time".

Many of the WGPs taking part in this Study had experienced negative attitudes of male GPs, one comment being:

> Flexibility is available now but many male GPs are derogatory about women 'opting out' as they see it. This issue needs the support of College Council of the RACGP the AMA and university to address it.

## 6.17 Self-esteem, Self-image, Autonomy and Control Over One's Professional Life

There was a wide range of views on self-esteem, including the following:

> Although I think that this extends to women other than GPs I see that the current medical community is a reflection of society and women have an issue with self-confidence.

> A strong sense of self-esteem is essential for happiness. We tend to put ourself last. It is very easy for women to take on a

> carer to nurturer role and take too much responsibility for patient time. It's a pity if self-esteem is lost.
>
> Self-esteem is difficult when we are expected to be all things to all people. Getting in there and getting on with life builds your self-esteem and self-image; rolling with the punches and focussing on the small things of life.

Strategies for building self-confidence and self-esteem that were suggested by the WGPs included placing emphasis on the building of self-esteem and self-confidence in undergraduate and graduate medical courses run by the AMA and the RACGP, and forming women's workshops for counselling and meditation.

## 6.18 Having a Voice and Share of Power in Decision-Making about Issues Affecting WGPs

The WGPs agreed with the view of one of the participants in the Study that; "Many decisions were made by males working full time and women's issues were not addressed by male bureaucracies". Women sometimes felt uncomfortable in taking the lead and as one WGP explained, "I often notice in a big meeting that I am invisible. It is often hard to be empowered in a mixed gender setting. However, having a presence and share of the power follows naturally from a strong sense of self-esteem and autonomy with control over one's professional life".

One WGP revealed her fear that there may not be any change saying:

> There needs to be a culture change at all levels, [namely] College Council, the senior bureaucrats and the national level in the RACGP and Training Program. It seems very unlikely and it is depressing to think that there won't be any change. At State Faculty levels women must be encouraged to join the boards and committees.

"More support for females in politics" was the suggestion of a WGP who maintained:

> One cannot complain if one is not prepared to get involved. This is important as women numbers are going to increase in General Practice. Females should be involved in all levels of discussion and constitute one third of all committees e.g. the RACGP.

To facilitate greater involvement of WGPs, a participant suggested; "Many women are estranged from these avenues because of domestic commitments. They could be involved in planning without committee work and all committees should include a part-time female GP".

The experience of a rural WGP was that this problem had improved for her since she had "training in stress management, conflict resolution and self esteem". She added:

> Being forced into becoming a political doctor by being a private GP in a mining community on aboriginal land where health had become a real political issue I have gradually learnt to play politics. Initially I felt I didn't want to be a troublemaker and was self-questioning. With time and experience it was easier to stand up for what you believe in.

## 6.19 Conclusion

This chapter has reported the key issues identified during the Delphi Study concerning the professional and non-professional lives of the WGPs. These issues included job satisfaction, balancing of one's professional and non-professional life, issues of time, and the need for flexibility and juggling. Finding time for relationships with a partner, children, family, social contacts, friends and the opportunity for non-medical interests were also seen by the WGPs as key issues. Other key issues identified by the WGPs were self-care, self-esteem, self-image and having a voice and sharing power in decision making. These issues will be addressed in more detail by exploring the results of the semi-structured interviews conducted in the light of the Delphi Study, which is the subject of Chapter 7.

# Chapter 7

## Key Results from the Semi-structured Interviews

### 7.0 Introduction to the Results of the Semi-structured Interviews

This Chapter presents the analysis of the themes from the semi-structured interviews. The themes are tested with the data (the words of the semi-structured participants), built upon and refined. The result is that the themes fall into categories that are represented by the components of the final framework (Appendix 1). This final framework is directly related to the research exploration of this thesis, namely the key issues in the professional and non-professional lives of WGPs in Australia and the socio-political space that they occupy in the medical profession and organisations and Colleges, concerned with General Practice. The analysis of the themes are reported in the following sections of this Chapter:

Section 1: Relationships and Self-care.

Section 2: WGPs in the Professional Workplace.

Section 3: Masculine Power and Patriarchy.

Section 4: The Difference between Men and Women and Generational Change.

Section 5: WGPs in Medical Organisations and Colleges.

# Section 1

## 7.1 Relationships and Self-Care

### 7.1.1 Introduction

The interview participants identified that relationships with their children, partner and extended family were fundamental to their success and happiness in their professional and non-professional lives. Self-care was especially important to the WGPs as their well-being was essential to building and maintaining these relationships. The WGPs chief concern was the provision of suitable child-care for their children.

### 7.1.2 Child-Care and the Needs of a Younger Female Membership

The availability of child-care was often raised during the interviews, it being a critical issue especially for WGPs. Some participants felt that they lacked support in their professional lives for the provision of child-care and there was an absence of a "caring attitude" for young families. They concluded that the College (RACGP) had not "come to grips" with the increasing female membership. Some WGPs developed innovative ways of dealing with child-care as one WGP said:

> There are a lot of solutions or potential solutions if the work place had a more caring attitude about child-care and other issues for women.

A senior male RACGP member spoke of the importance of child minding for younger WGPs and how child-care was mixed in with educational activities and professional activities. He was not convinced that the RACGP was dealing with this in any way:

> I don't honestly believe that the College has come to terms with the fact that its membership is significantly female and that they have some different requirements, particularly younger females. The issue is around child minding and how people mix the care of young families with work.

### 7.1.3 Responsibility for Child-Care

One of the rural WGP felt that caring for a family and child-care should be a more equal responsibility of the adults and that women should not be making all the adaptations to care for the family:

> Men tend to put women into a family role but it should be that when you are talking about family and who does what, it is both partners not always women making adaptations. Those days are gone. Obviously you have to make adaptations when you are having babies but it is much more of an equal thing now.

The issue of women's rights and the cooperation of men in undertaking home chores when WGPs were involved in professional pursuits was the concern of a rural WGP:

> I think women need to actually be taught to realise they have these rights. You'll get these women who are on top of everything but they still have to go home and do all the tasks that nobody wants to do. I think they need to stand up for themselves more.

A senior male GP spoke of "advantage" as being the basis for addressing parental responsibilities. He thought that the provision of child-care was especially important for younger practitioners:

> I think it's inevitable that if we move towards addressing some of these issues it's going to give people advantages that currently we don't give. The idea is looking at child minding and building that into courses and recognising that people do have parental responsibilities. For younger practitioners I think it is one issue that is important.

Women who do not have children are spared the demands of child-care and the time and interruptions that it causes. One WGP who had experience in educating GP registrars spoke of the need for flexibility to make time in a WGP's working life to cope with the major issue of caring for children:

> Women still have the children. That's a difficult one to overcome. In their private life if they don't have children perhaps it's not such a huge issue. If you have children obviously women tend to take the lion's share of the load of caring for kids and that doesn't leave you as much time to do anything else. Kids get sick and you've got to be able to work

around a bit of flexibility in your working life. I think that really is the major issue.

### 7.1.4 Options and Difficulties in Providing Child-Care

The difficulty in arranging babysitting especially when meetings are held at inappropriate times for WGPs was addressed by one female participant. A rural WGP explained how one organisation arranging educational activities for GPs, ensured child-care was available so that the wives of male GPs could attend the social events, yet the organisers neglected to consider that the WGPs might require child-care so that they could attend the educational program:

> Organisations are providing child-care for the social events and not the educational events. They provided child-care because the doctors' wives would want to go to the social events. The WGPs felt their needs just weren't being considered.

A number of options for child-care were described by the WGPs. One was having a housekeeper or nanny in their home, this allowing flexibility and freedom but imposing a large financial cost on the family. A WGP felt that this system enabled her to spend quality time at home with her children and husband:

> I've always employed housekeepers, nannies and people actually in the house, (at great expense mind you) to maintain a solid foundation at home. This has allowed me more freedom to spend more hours at work and time at home is quality time with

my kids and my husband.

When one urban WGP was expecting her third child she employed a nanny full-time who also helped with the domestic chores. This was a satisfactory arrangement for providing child-care and allowed the WGP time for other activities:

> When I had my third child my full-time nanny started to work for me. She lived with me for two years. When I was at home she was helping out with home chores and washing and everything else. I was actually then able to give time to my children, to play with them or attend things. Having a nanny was the best thing we could have done. They [the children] were very, very happy in that situation.

Knowing that one's children were being well cared for allowed a rural WGP to work and engage in other activities:

> Oh, child-care is the major issue. I've been really lucky that my kids had the same carer from when they were born. Knowing that they were being well cared for has allowed me to move on and do the things that I've done. My husband worked funny hours, and therefore he was home at times that other husbands wouldn't be, or he was away leaving me to cope with everything.
>
> Originally the children went to the child carer's home. It was one block from my surgery so I could literally go down and breast-feed them when they were little and then come back.

> Later on when they were coming home from school the carer would catch a taxi over and be at our home until I got home in the afternoons. They still go to her home at weekends if I am away.

Providing child-care may be easier for some WGPs now, as there are a variety of models of care available but their operating hours and the cost is still a difficult problem said one WGP:

> There's a lot more variety in what people can choose for their child-care. Child-care is actually not cheap and you have to earn as much as you can to pay for the child-care.

If the partner's work is flexible he can assist with child-care, as one WGP had found:

> I have a husband who has been able to be fairly flexible. He's got his own legal practice and so over the years he has taken afternoons off when the children have needed a parent to go with them somewhere.

### 7.1.5 The Effect of Child-Care on the Careers of WGPs

In the past child-care may not have been an issue for medical graduates as marriage and child bearing were often delayed until postgraduate training was completed. For women who wished to specialise, choosing to have a family became unrealistic. Consequently, some women doctors remained single. A female participant who had

experience in a specialist discipline said:

> Child-care certainly was not an issue for me, as I was single. I think that's one of the other things that has changed is that there were small numbers of women in medical schools. Nobody got married during their undergraduate careers. Most people delayed marrying or raising and bearing children until they had finished their postgraduate degree.

A male GP also recalled how women intending to be become specialist doctors believed that becoming a specialist and a mother were incompatible. He reported that some of the women students said they wanted to become specialists and they spoke of the fact that they would never have children.

One WGP described her struggle with the combination of work, care for extended family, study to prepare for the RACGP exam and arranging suitable child-care. This burden prevented her from continuing in full-time General Practice and caused her to stall in studying for the FRACGP examination:

> At that stage we were thinking that we wanted to start our family and therefore full-time work was not going to be possible. I had decided that I would have to take leave of absence or work part-time if I were going to be a mum and study at the same time. I wouldn't find the two easy to do together. I decided no, that it was too big a hurdle given that I had an ill mum, an ill father in law, and a family situation that didn't provide for it. I found as I had more children that my capacity

> to study and even look at doing exams just diminished. I wasn't one of those people who did very well at trying to study, raise children and work.

A male GP related the following discussion he had with a senior female GP academic:

> I remember a female professor saying that being a woman was not the problem. Having children was the problem for her career development. The glass ceiling is that women are held back in a chronological sense by time out for child rearing. They're up to five years, even up to ten years behind males of the same age in terms of career development. That's what they're fighting, not so much necessarily their gender.

### 7.1.6 Setting Priorities

Sharing the workload within a family was addressed by one WGP when she had to make medicine her priority:

> I can never remember being more appalled than when I went to a course at the Police Academy. The doctors turned out to be mostly women who were involved with working with victims of sexual assault. They had a really interesting evening which involved role-playing which made it much more real. All the women who were there and lived in the city had to go home and cook tea. (Laughing) Unbelievable! They hadn't given it (the evening) any priority or their family hadn't seen that if you are

going to do this you have not got to do that.

In the experience of a male GP in a Division of General Practice, priority setting and time-management were the key factors for WGPs with regard to their family and professional activities rather than earning money:

> In our Division the board made a decision that they would pay the child-care costs for any board member attending board meetings. We used to have our board meetings at 7 a.m. to 9 a.m. We didn't want to exclude women because most of the GPs in our Division at board level are in the age group of 30 to 45. Women of that age group are child rearing. We wanted to remove that obstacle. Women GPs were paid $100 to attend a board meeting and paid $90 in child-care fees. Payment on its own didn't make a lot of difference. I think it was just this whole thing of time management. Women who have young children, a family, a practice and a Division, well, the Division is probably number three on your list of things.

### 7.1.7 Clinging to the Traditional Role

From her experience in working in Australia and the UK one academic WGP compared the approach to household chores and child-care of the women in the respective countries. Employing home help and nannies was the culture of care in the UK whereas in Australia the women tended to carry these loads themselves:

> I think that women were probably more forthright in the UK and

> acted collectively, not as individuals. Collectively they were a bit more assertive about their role as women, both in speech and action. They really didn't feel bad about getting nannies to look after their children. That's something I found here, nobody gets help in the house. So many I meet go home and do the washing. I think that's really crazy. Give someone else a job and share your wealth. You can't expect to cling to this traditional housewife role and do everything. You don't have to feel guilty about it. Women tended to expect their partners to have equality but it was less equal for the women at home.

### 7.1.8 Relationship with a Partner

One WGP who was in the surgical training program prior to entering General Practice found that her relationship with her partuer was placed under great stress by work and studying for exams:

> I found it very difficult to work extended hours within the hospital situation and to study as well. The first two priorities were to actually complete my work and to study. My relationship and my social life were so jeopardised that people started inviting my partner out and I wasn't on the list any more. I started feeling quite distressed. In reassessing where I was going my partner, said "Well I think you had better rethink it because I had made a decision that you had three months to pull yourself together otherwise I was leaving". So my relationship was in great danger.

When this WGP explained to her male mentor (a surgeon) that she was rethinking her

situation his response was that this was his life experience as well:

> He was so committed to work that he was happy to put in danger all of his relationships. The only thing that he had maintained from the beginning of his training was his marriage and that had been very stressed as well. There was really no need for that to be the case.

According to a rural male GP, unequal relationship between a couple are sometimes sustained by medical women but feeling secure, sharing the domestic chores and being supported by their partners was not the case for these women. They were required to maintain a pleasant exterior and accommodate their partner's attitude:

> A lot of women having gone through medical school still come out with relationships that are unequal. They don't have the fortune of feeling secure and supported so that at the end of the day they go home and do the washing and cook tea. That's while their husband comes home and puts his feet up and drinks beer. I mean that happens in a lot of jobs, even for female politicians. A lot of professional women once they get in a relationship they get cast back in that role of doing jobs which neither of them want to do. They have to define a relationship in a pleasant and asserting way. For some reason they still want a relationship and they're prepared to have one for a while, on what I think is unequal terms.

The experience of another rural WGP was the antithesis of this. She was married to a rural GP and they

> ...split the work, shared sessions, after-hours, bed making and cooking. They supported one another and both like work. However, the family comes first. Whenever you have to make a big decision about things, you stop and think, family comes first and look at it from that basis.

Male GPs appear to have relationships with women who will support them but women don't often have similar support from their male partners. The men negotiate with women and may or may not support them as equal partners, whereas the women support their male partners unreservedly. This was the observation of one WGP:

> Men GPs often seem to get women who will always support them in the role as the GP. The women have to be the support for everybody. Males don't devote their whole lives to supporting us in our careers. They negotiate with us...but the woman subsumes all of her wants and needs to support this man. No woman ever gets that.

Having a "wife" at home was the desire of one WGP. Providing training for medical spouses was her suggestion for assisting men to get used to their wives being professionals:

> I often used to say to people it would be fine if I had a wife at home. I think medical spouses really need to be prepared in some ways. I don't think two professionals in the house ever run easily. This is a transition time for a lot of men as they get used to their wives being professional.

A senior WGP had observed that its often a WGP's partner who dictates where they are geographically located and this may cause the woman to give up her career:

> Often it's the partner that dictates where they actually end up, what town. If they've got to go overseas, it will mean that the WGP may have to give up her career and it's not so easy to find work if you move to another State and lose your contacts.

### 7.1.9 Damaging Relationships

A male rural GP admitted that he had seen male colleagues involved in professional activities and politics damage their personal lives, and their relationships with their wives and children suffered. Women were not prepared to do this to the same extent:

> Women colleagues who are involved in their profession, their personal lives inevitably suffer in much the same way as their male colleague's personal lives suffer. Children grow up, and perhaps spouses grow apart if they don't share the zeal. Where spouses share the zeal and are prepared to play a supportive role there is often a lot of very binding interaction. The involvement in professional affairs is deleterious to the core relationships. A lot of women recognising this often have a brief attachment with political activities because they are not prepared to risk relationships in the same way that male colleagues have tended to do in the past. It's also true that males are no longer prepared to risk relationships as they have in the past.

A woman GP said that "power balances" tend to exist between couples especially regarding income generation:

> There are also real power balances in relationships. I am married to a non-medical person and we went through real crises. We had to identify the fact that my earning potential was so much greater than his. That's one of the reasons why I work part-time to maintain this sense of equity within the household.

### 7.1.10 Women as Nurturers and Carers

Women not only bear the children but also have a greater commitment than men to nurturing a family. According to male rural GP:

> Biology has a big impact on women in that they do bear the children, they do have the maternal role. Whether it's nature or nurture I'm not certain but they have a much greater commitment than men traditionally have had to nurturing a family when women are younger. When women get beyond their major family caring duties, their interests are more similar to the interests of men.

Another male GP said that the key challenge for women was taking the responsibility for their family and husband and also coping with being a professional in medicine:

> Married professional women with children set up really challenging dynamics with coping with what is probably one of

> the most difficult professions. You manage the challenge and family, particularly when your husband is likely to also be a full-time professional mostly medical. All the women I know who are in General Practice, are the major responsibility-takers for their families.

### 7.1.11 Self-Care and Finding a Balance

A rural WGP reporting on research she had conducted said:

> Rural WGPs found difficulty in obtaining health care for themselves particularly accessing gynaecological services. One woman described how she had to travel 300 kilometres to have a pap smear, because her husband was a doctor and he didn't want to do it. The partner in the practice didn't want to do it, the doctor at the next town didn't want to do it, and the local women's health nurse refuse to do it.

Women take on multiple roles and responsibilities. According to one rural WGP:

> You do take on great responsibility and it always has been that the women GPs have had the responsibility for everything, managing their own life, looking after patients in their practice, ensuring the physical and psychological well-being of their children and probably looking after their marriages without the men in their lives, sharing that load.

WGPs care for their husband and children but they are slow to make self-care a

priority. Through the Medical Women's Society WGPs found they had an opportunity to model self-care:

> When the Medical Women's Society started off and the women first came along to meetings they were like kids being let out of school. This was somewhere where they could really say what they thought. We wanted them to go away and have a weekend at a health farm. Nobody would take it up. They said no, I have to do all of these things for my family and my work and I can't possibly get away to look after myself. We've actually got something like eight or ten takers now who will take the time off to care for themselves.

WGPs have to balance their private and professional lives. Getting the balance right is important to prevent burn out said one rural WGP:

> It's the balancing act. I think more focus is required in your private life in terms of time for yourself, to do whatever you want and time for your family. Getting that balance right so that you don't burn out is important. Childcare, schooling, involvement with school, time for partner's occupation are some of the issues of organising life and work to provide a balance.

### 7.1.12 The Causes of Exhaustion and Not Coping

Being a WGP who is also expected to be the caregiver and nurturer was difficult as one rural WGP found. For her equality equated with exhaustion:

> I think women in General Practice and all women in professional life in our society have a very hard row to hoe. We are still expected to be the caregivers and the nurturers at home. We are still expected to pick up the kids from school and help them with their homework and play an active role as a professional person as well. The price you pay for having equality is exhaustion. It is as simple as that.

The following experience of a WGP exemplifies the lack of consideration shown by some rural male GPs when she was pregnant:

> When I was pregnant with my second child, (my eldest two are only 18 months apart) we were living in a country town. I was a one of three associates in this practice and I was really keen. I did obstetrics and when I got pregnant and had the first baby I used to cart her along to the labour ward. There was some concession about the after hours roster when I was pregnant the first time around.
>
> When I wanted to take time off the second time around, you know the friendship really got a bit thin. The guys I was working with weren't keen on me dropping my share of the practice expenses. They felt that they had already made enough concessions to me and the other doctors in the town were extremely difficult about me coming off the after-hours roster. All I wanted to do was come off the general roster and just do the obstetrics. I was still quite happy to do that. I was the only female doctor in the town and the only one with really young kids.

> It was the older male members who just more or less said, "You want to be a doctor sweetheart this is the deal". There was no real understanding. Rather than face that situation we actually decided that it was easier to move as my husband (who was not a doctor) had been offered a partnership in another place and we just left the town. It just seemed like the right thing to do at the time and ostensibly we left the town because my husband got offered this partnership in this other place. A big factor was the fact that I wasn't coping.

### 7.1.13 Guilt and the Mental Health of WGPs

The rural WGP referred to above spoke of a burden of guilt that she carried. She felt guilty about fulfilling a professional role and at the same time caring for children, a husband and a home:

> Working mothers generally, and maybe women doctors in particular, seem to carry around this enormous burden of guilt. You are guilty if you are not fulfilling your professional roles to your own set standards because you want to be a good doctor. You are also guilty all the time because you are not home for your kids and you are guilty because you've got a messy house. You feel guilty because you are not doing your share of on call and you feel guilty because you are not some sort of super-woman. You feel guilty because you haven't paid your bills or you haven't had time to do this or that. You feel guilty because your husband has his own needs and desires and he expects some support from you as a wife. So basically you are just wandering around with this burden on your shoulders most of the time. That's even without taking on College responsibilities.

(Laughs) Have I got it in a nutshell do you think?

Later this rural WGP was in practice with another GP. This structure was unsustainable and again she felt unable to cope. She decided to care for her mental health and set her priorities so that her husband and children came first and medicine came next:

> In the last few months I have had to make a conscious decision to look after my own health particularly my mental health and that's actually got to come first. I have been in an unsustainable practice situation with two partners, including myself, and in the end I just couldn't survive any longer and I was cracking up. You have got to put yourself first which none of us do very well and then if you put yourself first the other things fall into place provided your priorities are right. Your priority is your husband and your kids and unfortunately medicine has to come next.

Having no one to go to and nowhere to go in a small country town when life became difficult was the bitter experience of this rural WGP:

> I think that when things got really bad for me in the last few months, I actually got to the situation where I had nowhere to go. I couldn't go to any of my colleagues in a small country town where I worked because they are just not supportive like that, and also going and looking for support all around automatically means you are a neurotic woman. You are looking for sympathy and doctors don't look after one another at all for that. It is all right if it is a physical problem but if you

look as if you are cracking up and you do something like drop out of an after hours roster of course you are going to increase their work load, so no body wants to recognise that. So having someone you trust is important.

Eventually this rural WGP coincidentally discovered that in the same town another WGP was having similar difficulties. By combining forces they were able to resolve their individual problems:

The woman I just joined was in the throws of a marriage break up and she has been through a terrible depressive episode. It's just tragic she is a great GP doing heaps of obstetrics. I wasn't coping either. It is amazing you have got two women in a small town both of us doctors, both of us with obstetric skills, neither of us recognising we were close to cracking up and burning out until it got to the stage I was desperate. She left her husband and I walked out on my practice virtually within a week. It just happened she rang me and said "I hear you had a bad day". Anyway, I went off on a holiday with my husband and basically said I would rather be unemployed than feel like this.

Later she rang me and I said look I don't want to do this any more. I said, I only want to do two sessions a week. She said, "Do you want to come and work with me?" The problem immediately sorted itself out. It was interesting because going into a job-share and getting off the after hours roster fixed my problem. By reducing her obstetric load and passing it over to me and getting a better roster fixed her problem.

# Section 2

## 7.2 WGPs in the Professional Workplace

### 7.2.1 Introduction

This section reports the issues raised by the interviewees regarding their professional work. These issues include practice ownership and management, work practises, models of practice, work in rural locations and remuneration, conditions of work (including safety and support from spouses), balance and equality, and education and training for GPs.

### 7.2.2 Women General Practitioners in the Medical Workplace

A male GP interviewee who was in a senior College position thought that "the entry of women into the profession has meant that their attitudes have coloured the profession as a whole". However a WGP participant gave quite a different perspective:

> What has been really good that's come out in the last few years is in fact that General Practice is a totally different discipline from what we were role-modelled on in the hospital life. Women with their networking and social skills are very well adapted to General Practice.

Another male GP who had extensive General Practice experience in the RACGP Training Program believed that history, sociological and environmental factors were closely linked to the presence of women in the workplace:

> I think it's complex and has to do with the history of women in the workforce in general and what happens in a variety of industries and how women are perceived as being knowledgeable compared to men. How women have had to gain higher levels of academic qualification for the same positions as men. There are a lot of general environmental and sociological things.

The same male GP thought that there were gaps in the knowledge about WGPs' pay, work conditions, continuing education, status with male counterparts and rightful recognition. He considered that this situation may be concerned with "male dominance":

> For women in medicine, I think there may be factors about how women address issues of pay, conditions, continuing education and status with their male counterparts and their male bosses. I wonder whether women have been less than ideally or optimally effective in the past in claiming or getting their rightful recognition. It's just a societal thing about male dominance.

The dilemma for WGPs regarding how much work they intended to do was encapsulated by a male GP:

> The difficulty is to meet the various expectations especially if you become partnered and you want to have children. I think that women often find it really difficult to decide how much work they're going to do, how it's going to impact on their family life with their children, their spouses and their professional colleagues both male and female.

Although General Practice was said to be leading the way with the participation of women in the workplace, a male GP contended that in other industries, where women were in the majority, they tended to be poorly paid and valued:

> General Practice seems to be leading the way in terms of participation rates of doctors within the profession. In other industries where women make up the bulk of that profession or industry, it's low paid and has a perception of being a low value industry. We may see a situation where medicine divides into male dominated specialists arenas and female dominate General Practice which would then retard the progression of General Practice as an equal compared to other professions.

However, one WGP was optimistic about the position of women in medicine, saying:

> Medicine has led the field in a lot of professions in providing support for women particularly in General Practice. Women are older and getting their kids through school and it is easier for them to get involved. I think things have changed in the College and it just took time and there has been a conscious effort to

look at it. I feel very optimistic about women in medicine.

In contrast a male GP outlined his concerns for the future of General Practice that could result from the increasing numbers of women GPs:

> My big concern is that by making academic training for women less rigorous because of their femaleness that we're in danger of lowering standards. In making the job easier, we're perhaps also detracting something from their career. Having greater than 50% of the profession females who are not as involved politically or in positions of control of the College or the AMA, we run the risk that women, because they're not involved and interested, will not fight, which we need to do constantly for our futures. General Practice will be devalued as a result. Other Colleges I don't think have the same problem. I think they have fewer women and the women who are there are often more feisty and more prepared to stand up and argue for the future of their Colleges.

### 7.2.3 Practice Ownership and Business Enterprises

In General Practice there is a division between males who are prepared to buy practices and become practice principals and WGPs who are not interested in owning a practice and hence not taking a risk. Those making the major decisions in General Practice are male GPs working full-time. This issue concerned a male GP:

> When considering the relationship within practices between

> females and males the positives are that General Practice leads itself to part-time work. The trouble is that the nature of General Practice is changing and the people who seem to be making the major decisions are the ones who are putting most of their money into their own practices, namely the males who work full-time. Many of the male partners lament the fact that women won't put their money into the practices. The women only want to come and work part-time and go home or take an hourly rate quite happily. But they do not want to bear the risks.

The same GP reiterated a common theme that part-time employment was changing the nature of General Practice, and that the (largely male) owners of a practice bore all financial and other risks as well as a lifetime commitment. Employees in the practice (largely female) were in salaried positions for convenience:

> The nature of General Practice is really changing in a sense of practice ownership. If women want to be working part-time then the default is always going to be an employee type relationship. Unless you can define a true partnership type model that has got some sense of growth about it, you run the risk of high turnover of staff and the same problems with one or two people owning the practice and bearing the risk. The rest come in for a convenience for periods of time. It is very much a model of convenience rather than a model of lifetime commitment.

An urban male GP thought that there was a risk that business organisations may take over the ownership and management of general practices:

> For the future with people doing more and more part-time work and fewer doing full-time work, the thing that really concerns me is the actual physical ownership of General Practice. A lot of doctors and this isn't just females, don't want to be a managing partner or an owner of a General Practice.

One male interviewee was supportive of part-time work but felt uncomfortable about part-time GPs having all the advantages:

> Part-time work I think is great because I don't see why anyone should be condemned to a life-long 70-hour week. We can't have it all and hope that someone benign is going to be owning the practices.

According to an urban male GP it was harder for women to buy into a practice because of the financial commitment in their home and because their husband may be moved to another location:

> It's harder for women to buy into practices because they've often got financial commitments at home. The majority of women choose to be assistants because their husbands may be transferred or they may have to move away.

WGPs with children have also been reluctant to buy into practices or become practice principals said one city based WGP. She felt that uncertainty regarding the future also dissuaded women from buyiug a practice. However, she thought that a number of options were open to WGPs:

> I think women with children probably have been reluctant to buy into practices, or become principals in practices. I find that everybody is pretty reluctant to buy into a practice at the moment because of the uncertainty of the future. When I graduated GPs were reluctant to take women into their practices, and they were certainly very reluctant for them to buy into the practice. I think that has totally disappeared. You are much more a marketable commodity as a female than a male GP now.

When two urban WGPs were setting up their practice in 1987 the bank manager asked that their husbands be guarantors for the establishment loan required. One of the WGPs involved believed that this scenario has since disappeared:

> When we first started we approached the bank to lend us some money. Three days before it was supposed to all happen they said we want your husbands to be guarantors on this. Both of us had said right from the beginning our husbands are not to be involved in any form. If two men had gone to them to do that, they would never have said we want your wives to be guarantors.
>
> We basically put our foot down on the Friday afternoon and the man said I'm going to have to get in touch with my superior. We said well, we'll go elsewhere, because we knew there were other places we could go to and see what they had. We didn't know whether we would get it from them either, but we decided to call their bluff. On the Monday morning, they rang us and said it's okay you can have it.

It is uncommon for WGPs to own their practice and a male GP felt that education in practice management, business and ownership needed addressing so WGPs could choose to be self-employed:

> Despite one third of women being in practice, it is extremely rare still for there to be all female practices which are owned by women.

### 7.2.4 Management of a General Practice

A male GP who had had the experience of previously working as a principal partner in an all male practice now worked as an employee in a practice where the doctors were all female. He witnessed a very different management style:

> Having been principal partner in an all male owned practice in which my wife worked as a paid employee and now being a paid employee in an all female practice in which my wife is an owner (there are four other women in the practice) the thing that most powerfully struck me about it was its management style. It is absolutely different. I previously worked in a very nice practice with very nice men, you know the wishy washy side of the male spectrum. I thought they were thoughtful, insightful and worked hard on consensus. But working in my wife's practice is a real revelation in the way they deal with their staff who are all women. The way they deal with the organisational aspects is an endless observation of mine. Sometimes it drives me nuts. Then I look at it and think, no they are actually doing something about it, but they're not doing it the way I would do it, and not

> the way I think the average bloke would go at it. It's actually a very pleasant place to work. It is different and again in many ways I think better.

This GP likened the style of management that the WGPs used to the way mothers run a family. He acknowledged that the WGPs process avoided conflict:

> The management style is not directive, and it's not as dogmatic and from a people management point of view, it really is very egalitarian. Very much like running a family. It's like watching Mums run a family versus Dads run a family. I don't dare even offer a suggestion because it actually works really well and it's a pleasure to work in and all I would do is muddy the waters. Are all like practices like this, or is this just an oddity? I think that probably it is more a matter of a style really. I don't think it's an oddity at all. They desperately avoid conflict to a degree where men wouldn't tolerate. Yet it works and I'm dying to lay my hands on it, but I resist the urge because again I recognise a superior process. I've just got to get out of the way.

The male GP (referred to above) pointed out that in recent times WGPs had taken the responsibility for running the business, including finances and human resources in their general practice:

> I'm married to a full-time GP and we have shared our careers now for nigh on 20 years. I go with the part-time GPs now. I'm the token male in an all female practice.

> What are the key issues? They're exactly the same as male GP key issues, they're how you practise your profession effectively and how are you good at the job. I see no difference in a sense between women and men in that area. Many of those women are also taking up the challenge of running and managing businesses which is a relatively new phenomenon. It is still a relatively rare phenomenon for women being the full-on partners and the majority partners in practices. They are responsible for the business, its financial well-being and hiring and firing staff.

It was the opinion of one urban male GP that female GPs who had never owned a practice did not have the knowledge required or a business perspective, while those WGPs who had this knowledge shared more of his attitude:

> There are disadvantages [not just for female GPs] as very often they've never owned a practice or run a practice. They don't have the knowledge which is important to keep it viable. That's something that I've always struggled with, with my various employed doctors. As far as female GPs who are actually partners or associates in the practices, I've never have actually had that personal contact or first hand experience. A lot of my friends are in those circumstances and that certainly seems to work well. My observation is that those women have a different attitude to General Practice from the employed doctors. They have more my attitude because of the financial and administrative side of it.

This male GP also claimed that WGPs had not been trained to think along business

lines or had the education necessary to make them aware of the details of practice management. However, he thought that the wife of a specialist who runs his private practice would understand what is involved:

> They [WGPs] haven't had to be involved or think about some of the aspects. It varies considerably and I wouldn't say it about [Mary] because I think her husband is a specialist and runs his own practice and she's aware of a lot of these ins and outs. I think that's the main reason they haven't had to do it. They undoubtedly haven't been trained to think along those lines, or had the education.

He also referred to the difficulty that he believed existed when trying to get WGPs to charge appropriate fees especially for long consultations:

> When we're working on a fee for service basis and when you really have to be acutely aware of costs, not only your own personal costs but the costs to the community, then I think it's very important that the doctor has to be well versed and broad minded in that aspect of practice. A classic example is that it's almost like pulling teeth to get female GPs to charge for long consultations when they've plainly done it, and gone way over time.

One WGP noted the importance of receiving education in business skills and the lack of training available in this subject in both the undergraduate and postgraduate curriculum. She saw a role for Divisions of General Practice in training GPs in

practice management skills.

### 7.2.5 Job Satisfaction

A rural male GP believed that satisfaction in General Practice work is related to the practitioner's knowledge about the patients attending the practice. A rural WGP also supported this belief:

> With professional life, getting sufficient job satisfaction is about the amount of work that you're doing, the quality of the work that you're doing, the direction your work is going, and whether you feel you have control over the direction or someone else does. It also depends upon the opportunities that are presented to you and whether you can create new ones.

Another male GP felt that job satisfaction was sometimes lacking because of his training resulting in a "subtle macho" approach to being a doctor. One was expected to endure long work hours without complaining and without appropriate pay:

> There is a sort of subtle macho approach to being a doctor that is instilled during your training. It's the norm to work 60 hours a week as an intern and as a registrar and that you do it without complaining and you do it without being paid. That's how it is. If you're not good enough to do all that, well you get out and you do something else other than medicine. Men have accepted that over the years. To take it to the next step is being a solo GP in a country town on call seven nights a week. It's a

> continuation of the reality of that's how life is and you have to work those hours under those circumstances to be a good GP in a country town. One has reinforced the other.

One of the male GPs acknowledged that with the increasing number of WGPs, adjustments will have to be made to cater for how much work they can cope with given their other roles in their professional and private lives. Then satisfaction for the WGPs will follow:

> In my working lifetime, about one third of all GPs are women. By the time I've finished my working life more than half, anything up to 60-70% may be women, so it's not a choice issue. The adjustments will have to be made. I think what we have to do is be realistic about what people can do. Acknowledge the excellence of what's being provided and that there's better care that's being provided. Then start developing the structures that allow that to happen.

Equality in a practice is important but continuity of care provided satisfaction for one rural GP:

> Just being equal in a practice is really important. Obviously it is the one-to-one satisfaction thing. I think being able to have continuity of care rather than coming and going is what makes it professionally satisfying.

### 7.2.6 The Way WGPs Work

Women have often chosen General Practice because of the availability of part-time work. A male GP thought that women had "chosen well":

> Work practises have militated against women choosing specialist careers and they've chosen General Practice. They have just chosen to work part-time as a consequence of not wanting to live a full-time in practice life. Now men are starting to reject full-time practice. I suspect that the message that came through was this is how it is, and it will always be. Women have chosen well.

Women have a different work style according to one WGP and they prioritise their relationships and professional lives in a different way to men. Some male GPs working part-time also feel the barriers to their professional participation and the perception by others that working part-time is not being a "proper GP". However, according to one WGP patients readily accept part-time work for GPs:

> The thing about it is that we work differently. I would put my relationship above most things, and I would put my quality of life pretty high up there as well, and then I think comes my professional life. It hasn't always been like that. I've actually lost the path a couple of times, but in really sitting back and working out why I do what I do, then my objectives become very clear. I've heard the same sort of problems being identified by men who are working part-time. They have this sense of

barriers to their participation that they're not really seen to be a proper GP.

It is a lot to do with our profession's identification of us. Most of the patients are actually very accommodating and very accepting of this, as long as they know what they're in for up front.

The same WGP provided long consultations and favoured a family-oriented atmosphere, warmth and emotional commitment. However, she could only manage this by working part-time because full-time work exhausted her:

We've recently reviewed our styles of practice. There are three women and one man in our practice and I have twice as many long consultations as anybody else.

My way of dealing with the fact that I often run late is to make sure that everybody knows that I care, and that it's very much a General Practice for the family. I like walking out into the waiting room and saying to somebody who I know is there, "Margaret I'm running half an hour late, if you want to go and do some shopping, it's okay". There's a lot of warmth that's exchanged, a lot of emotional commitment.

I always ask "Is there anything else I can do for you today?" I think that I've trained people to really push and to use my services. I find that I can manage that part-time. If I do it full-time, I am so exhausted, and so emotionally concerned about these people, that I actually don't have enough to interact for a quality relationship with my partner and with my friends. When

> I work full-time, I don't want to see anybody. I want to hibernate. I want to garden. I want to do solitary activities for the rest of my time, and that actually has an enormous impact.

Communication and discussion with patients was seen by this WGP as a way of reducing stress for both the patients and the GP:

> When we first started doing practice newsletters I worked very hard to get women to a write in about their concerns. There were several letters about how do you cope? What are the strategies to reduce the stress, especially the significant stresses of running late?

WGPs are interested in doing a variety of professional activities in General Practice. A rural WGP said that working in a community rather than procedural work was the attraction for her:

> My gut feeling is that a lot of the time when women go into practice they are interested in doing different things. The thing that attracted me to rural practice wasn't being able to do lots of procedures. It was the opportunity to work within a community. I think that that seems to me to be something that interests women a lot more than men. The whole thing is being part of a community and working in that community and being able to provide holistic health care.

The number of sessions a WGP does in a week was the focus for one male GP. He questioned how many sessions a WGP should do to ensure her confidence and

competence and make her contribution viable for the practice:

> There has to be some sort of problem of staying abreast of the professional aspects of their job. How many sessions do they need to do a week to stay competent and confident? How many can they afford to do to allow for their other activities, particularly family? From my own practice point of view, there has to be a certain number of sessions that a female practitioner will do a week for it to be a viable proposition for the practice.

One WGP described how her practice sought to overcome differences in medical practice between the doctors and how they established principles for handing over information:

> Ultimately the issue came down to if we were doing good medical practice. Were we looking after the patients in the way that they needed and requested, and living up to the standards that we'd set ourselves in terms of medical practice? We spent a lot of time in our practice meetings ensuring that the hand-over was good, that the changeover of medical information was good, that our notes were good. I think in part-time General Practice you have this problem that if somebody does something slightly differently from you, how do you actually overcome that when one patient might see both of you? We spent a lot of time looking at how we approach a certain condition, how we would treat asthma or hypertension, how we would follow through. If there were issues we didn't agree with we brought it up with each other first.

Speaking about the quality of the work of WGPs one senior male GP said:

> I have long had the view that in General Practice females have a better capacity to provide the sort of care that you regard as being the ideal comprehensive whole family care. There's no doubt in my mind that female GPs have unique qualities, which I think lend a lot to General Practice. It's great to be able to take advantage of that and use it within your practice.

Another male GP thought that longer consultations conducted by female GPs took place because of patient selection:

> I know a lot of female practitioners feel, and the data supports them, that they do a lot of the longer and more difficult and emotionally draining work in the field of psychological and psychiatric medicine. There is obviously a gender difference here that is largely due to patient selection.

The view of a WGP was that women patients perceived that female GPs understood their problems and showed empathy that male GPs did not. This however resulted in longer consultations and poor remuneration for WGPs:

> The patients certainly respect our professionalism as much as they do our male colleagues. The patients take advantage of women doctors in ways they don't of males. The vast majority of patients consulting GPs are women or children. Women perceive that we have a sisterhood there, and that we understand their problems and they're more prepared to discuss more time-

> consuming things with us because they think we understand, and we do. There's that empathy that I guess they just don't feel with the males. Therefore they're more likely to have more prolonged consultations. That's certainly been proven and that again makes it very hard for female GPs on the current bulkbilling schedule to maintain the same hourly income as males.

A male rural GP took a very dim view of WGPs providing consultations for patients who had been referred to them simply for women's health services:

> You still see in Australia ads for a woman that read "would suit female practitioner". That means that you are going to sit down the back and do pap smears. You're never going to get to know the patients. You are going to see patients that have been referred by GPs who haven't been prepared to do a very basic examination that would take less than five minutes. So you get people who have had incomplete General Practice and you're to go on to give them a bit more incomplete General Practice. Those patients have no commitment to you nor you to them and you know that's been bad.

A female participant noted that work patterns were changing with the increasing number of women in medicine, and old attitudes dying:

> Because there are an increasing number of women in medicine work patterns are changing. There's awareness of the changing patterns of the way that men work now too. The old-time battalion that we did it hard and you've got to do it hard is sort

> of shifting. The pressure on young women to meet the needs of their old-time consultants is still quite extraordinary.

A female interviewee who held a senior AMA position spoke of how the AMA 'safe hours project recommendations' acknowledges that it is unsafe to work excessively. She felt that the culture must change from a male-oriented work pattern in order to enhance the health of the doctor and his or her family:

> The AMA has started what's called a safe hours project but it's not gender based. Hopefully it will have an impact in gender arena where it will be acknowledged that it is actually unsafe to work excessively. The culture will change from what is called a male oriented work pattern to something that's a little more sensible. It will fit in better with the sort of health people ought to have and with the needs of family. Out in the non-medical workforce there is also pressure for men to work fewer hours. I think the women who work in male worlds still feel they have to work male work hours and if they don't they still cop flack. Not that I think that it is going to have any effect on me or my partner, both of us being workaholics.

One WGP suggested that women have a different style in their professional life in that they see the requirements of society collectively:

> In their professional life, I think women generally have a different style, a different brain patterning and a different socialisation to men. Although the medical process is quite a leveller and quite uniform, we all come out being able to

> achieve these tasks. I think that women not only work on a one-to-one basis, they also work with society. They see society and the needs of society probably differently from men. Women see it collectively.

### 7.2.7 Models of General Practice

One male GP was unsure if the groups of women who were establishing practices were "refugees from other models or whether they're in fact defining a path and embracing it". However, an urban woman considered that part of the professional identity of a WGP was that she was more likely to work for someone else and preferred to work in a group:

> We are less likely to be practice-owners and we are much more likely to work for somebody. There are very interesting different styles in practice. We prefer to work in group practices.

Women prefer to work in environments where there is flexibility for work hours and leave. This requires working in a team said an urban WGP:

> Women prefer to work in teams. They prefer to work where they have flexibility to take holidays when they need it, flexibility to determine what hours they work. There's a mutually cooperative sharing of patients and a teamwork environment. Women have been the leaders in the development of multi-disciplinary teams providing health services and I can

see that it's partly to do with this flexibility.

The same WGP explained that the provider number legislation had limited the flexibility of career choice and this has limited the practical experiences of WGPs:

> Since the provider number legislation the alternative pathways in medicine are being limited. The perception is that you either do General Practice with a love and a gusto or you specialise, or you remain hospital based. It is extraordinarily compartmentalising of medicine and it's not reality based at all. Having recently undertaken a rural locum, the lack of supports and the need to be really gung-ho all of the time certainly makes flexibility a really important issue.

It has not been uncommon for husband and wife who are both GPs to work together and jointly own a General Practice. This was the case for one male interviewee:

> It's my own experience of being married to a GP and working with her in the same practice. We've always worked together and essentially owned the businesses together. I've seen in that sense the trials of what it is like to be a female GP and the challenges that has provided.

The problem of practice partnerships for part-time GPs was raised by a WGP who ran her own practice and employed others. She was exploring the possibility of a company structure:

> It's not all that lucrative for me unless one develops partnerships. Partnerships for part-time GPs are very difficult. Most part-time doctors can't see the value of paying money in to be a part-timer. Practices need to look at how it can be valuable for a person who wants to work part-time to be a partner in a practice. We're looking at having a company with a set of ten shares. People can buy as much as they want to do or a little as they want to do. The financial issues are big ones.

One WGP explained that where General Practices were set up by a group of women there did not seem to be problems. In other practices women were excluded even though they had helped build up the practice:

> There are a number of General Practices I know where the practices started with a group of female GPs. There doesn't seem to be any problem in working out whether they are an associateship or partnership or how the money is divvyed up or how the power is structured. There still seems to be some problems with some of the other partnerships where females have had a position almost as a locum and then they build up a practice. They are often not considered part of that practice. Some of the females don't know what to do. They say "I'm here and I want to be part of it. I want to be heard".

An urban WGP related the history of her practice and how the time had arrived where she could not run the practice with WGPs working part-time. She therefore employed male GPs who she found were more ready to work out of hours. However, she still required WGPs to meet patient requests:

The practice I bought from a solo male in 1976 and it therefore became a solo female practice with some help from my husband who went on and became a specialist. By the time I had my first child four or five years later I took on a female assistant and it grew from there. At one stage we had five females working both part and full-time. At that stage which was three or four years ago, it became totally impossible because of the demands of females in the practice to continue to run a full-time, proper, suburban general practice with females alone. I took my first male and we now have eight doctors in the practice, three of which are female and five of which [are male]. Some of the males are part-time as well as the females. It's been a huge change but that's just based on the fact that there was huge demand for female sessions by patients and there still is. I couldn't continue to run it effectively on females only. There just wasn't the will there to work.

The males are very reticent to talk about the problems they've had with female doctors and the hours that they're prepared to work. There's the old cliché of 9-12 Monday to Friday. Is not quite correct but nevertheless I can really identify with the problems a lot of the male doctors have had employing females because you can't have it all your own way. You can't have all the school holidays off, and you can't be home at 3 o'clock every afternoon for your kids. I mean if that's the sort of life you want you shouldn't do medicine in the first place. There has to be some give and take. While I try to accommodate everything women want, in the end there has to be some loss situations for both the doctor and her family or his family. That's the nature of the job and the nature of the demands of the patients and they're not going to be re-programmed.

This WGP went on to say that that having children was not the issue as WGPs without children had other priorities that determined their availability in the workplace:

> I've had just as many difficulties with women without children making compromises for the practice as I have had with women with children. So I don't think it just relates to women who have got children. Women without children had other priorities in their lives. They were still not wanting to work after 3 o'clock in the afternoon or didn't want to commit to any Saturdays or to do any evening surgeries. When we have had difficulties it has been equally with the ones with kids and the ones without.

There are WGPs who are not partners in general practices and they are not able to actively influence the practice on practice issues. These women perceive they are viewed as being second rate said one WGP:

> There aren't a large number of WGPs who are partners in practices. They sometimes sense that they're second rate because they don't have a real say in the practice, that they're just going for sessions and not able to actively influence the practice on how it sees patients.

A male GP reflecting on the work practices of WGPs in his Division, thought that WGPs preferred part-time work. He reported a case of a WGP who would only be accepted as a partner in her practice if she worked full-time:

> One of our female Division board members had a perception that being a partner in a practice was impossible if you were a part-timer. She felt that within her own practice she was being unfairly treated. They were prepared to accept her as a partner, but only if she was working full-time.

### 7.2.8 Part-time Work

A male GP who held a senior position in the RACGP Training Program spoke of how balance between one's professional and private life could be effectively maintained by working part-time:

> The things I have heard most about, and therefore I've been most influenced by, are issues about capacity to work part-time, or at least in a way which is compatible with other responsibilities and other wishes. Thinking about professional life and about life generally women have professed to be more effective than men have, although men are catching up. A bit of balance about their professional and private lives, some sort of mixed role there rather than being dominated by professional life. There seems to be a lot of men that want to work part-time now. That may be simply a generational thing, not particularly a biological thing.

However, a WGP who had observed young registrars over many years in her role as State Director of the RACGP Training Program. commented that young men had begun to think as young women did about their career and wider interests in life. These ideas were in contrast to the expectation of older men:

> Many of the young men who are coming into the profession seem to think quite differently from the older men. They think much more like a lot of the young women who are coming in. Their thinking is around the whole way they want their career to develop and their various wider responsibilities and interests in life. They have different expectations of their roles as GPs. I think that even in the eight years there seemed to be a change that I observed.

Another WGP noted that there had been a change in the training rules for GP registrars that allowed access to part-time training for General Practice:

> There is enormous support for being in General Practice and for having part-time General Practice. I think the College (Royal Australian College General Practitioners) has actually made a big change in that the registrars as they come through are able to make the choice and not feel in any way that they're a lesser quality doctor because they're working part-time. I believe that the tide is changing.

A WGP said that pioneering WGPs had established a precedence for part-time work:

> Nobody questions the fact that I work part-time because there have been all these women pioneers out there who have had children and who encouraged other WGPs that they had to work part-time.

Another WGP who had extensive experience in General Practice felt that disparagement was shown towards those who worked part-time:

> I think that there's still an attitude that if people are working part-time, and many women are working part-time while they have their children, that there is a belittling attitude from some members of the College, the AMA and Divisions. I have the feeling that in this day and age it is not as acceptable to perhaps just do two or three sessions. I think there's probably that pressure on people.

Pressure was felt by a young WGP who was faced with the various professional roles that she had to confront. She had previously experienced a lack of diversity while working as a part-time GP:

> The issues for me were, how do I get my College fellowship in this time when I have children? How do I maintain a practice which people actually saw as valuable and didn't poo-poo because it was part-time? A part-time woman in General Practice was seen as being very much the person who just does all the smears in the practice, or just does all the counselling in the practice. During my first time when I worked for two sessions a week, that was all I did.

A male GP complained that WGPs working part-time were not taking "high profile" positions in professional organisations:

> What they do in the consulting rooms is very possibly part-time. I'm very concerned that women aren't taking a high enough profile on the issues of working conditions, pay and government remuneration. I think there are far too many women who regard

> their income as a supplement to their husbands, or General Practice as something nice they can do to maintain the professional contact.

By networking, two urban WGPs set up a general practice with each of them working half-time. One of these two WGPs observed how difficult it was to work part-time and maintain self-esteem:

> After my second baby was born I visited a friend who had just started a General Practice in her home. She said "Would you be interested in just covering me when I need some afternoons off? Would you be interested in doing my back-up?" It seemed that this was a good opportunity to enter back into General Practice.
>
> I started working with her, just covering her two afternoons a week as well as the three sessions I was doing in these other practices. We got on so well together and enjoyed working so well together that after my third child was born we decided that we would go into a General Practice together. We would each work half-time. At that stage we started to realise how difficult it was professionally to work part-time and to have the same sort of esteem in your practice that other people got when they worked full-time.

Although job sharing and working part-time provided flexibility for these two WGPs, they had to put aside their feelings that they could not provide a quality practice working part-time. However, some patients held a perception that the more hours a doctor did the better that doctor was:

> One of the big issues for women in General Practice is that there is a little bit of (and I think this still exists) poo-pooing of part-time practice, in that you can't do the sort of quality of practice if you are only available part-time. We started to become aware of that as we worked.
>
> We started to work through that sort of feeling [that] we weren't as good a GP as anybody else in the community. As we went along we started to realise that people came to our practice for a different reason than some other practices. They came to our practice partly because we were both psychologically motivated and we both had a philosophy that saw patients as whole people and not just someone who came in with a sore toe or whatever. We both believe in a long-term view of medicine. We started to develop very much a family practice in which they trusted both of us as their family doctor. As it got busier we employed someone else. This person wanted to work about three quarter time so once again we were faced with the question of "Was this third doctor a better doctor than us because she was working longer?" Some patients mentioned this issue.

A male GP observed that the use made of part-time doctors, particularly by WGPs may result in an intellectual schism in the profession:

> The main concern I have at the moment is that we are in danger of creating two classes of GP. The traditional professionally-orientated GP and the sort of part-time hobby GP. I would hate to see General Practice divide into that sort of arrangement based on not just women with a fairly part-time mentality but increasingly men doing the same thing. I don't think that that

augurs well for the future of General Practice.

> We need to be very strong and professionally orientated if we are going to survive the changes that the government has got planned for us. We have to be in General Practice professionally organised. Males and females together, as women physicians or women surgeon are. I don't think there needs to be two standards of General Practice.

### 7.2.9 Models of Work for WGPs who were RACGP Training Program Employees

A WGP in a part-time position as a State director in the RACGP Training Program reported that the College didn't cope well with different ways of working and she was essentially doing a full-time job in a part-time capacity:

> I was given the option to work part-time as a State director. In fact the system couldn't accommodate having a part-time manager. I was still expected to come to all the meetings and to be available 24 hours a day, seven days a week. It ended up that I was being paid less to do the same.

A rural WGP negotiated with the RACGP to work from home for the Training Program. She found this to be more suitable both professionally and personally:

> I've broken a bit of the mould in the senior management. Being rural has helped because I was able to negotiate a contract that

> has meant that I can work from home. That has revolutionised my life and meant that I can continue working. It allows me to think and be a bit freer than if I was having to come to the office every day. So it's better professionally as well as personally. It allows you to be much more flexible with your time and the family dynamics to continue to flow. Somehow I've managed to hit the right balance I think.

A male GP who was in a senior management position in the RACGP maintained that the selection criteria for positions in the training program was made on the candidate's quality rather than gender:

> We select very strictly on qualities rather than on gender. Then you get into that challenging area about is there a need for some positive discrimination in the organisation? Our history with State directors would suggest that we don't need it because we have had a very high representation of women. In our Medical Educators we have got a very good female representation, both full-time and part-time. Of course many of the registrars are women, the majority are.

### 7.2.10 Remuneration for WGPs

One WGP noted that superannuation and various types of leave have been foregone in contracts that WGPs sign with employers:

> There are real industrial issues with regards to how much we get paid and the conditions under which we work. Superannuation

> and parenting leave, sick leave and annual leave. All of these things are now legislated for, but we're all signing contracts just to forego them all and they've always been foregone anyway.

An urban WGP showed the interviewer an article that had appeared in the city's newspaper that day that highlighted the poor position of GPs with regard to financial reward for their work. She despaired that the situation would not improve, in view of the recent freezing of Medicare rebates for patient services by GPs. She outlined the poor public understanding of monetary matters when they went to the GP. The low government's set schedule fee and Medicare rebate for GP services, the discount the GPs accepted for bulk billing plus the lack of remuneration for the time she spent on the paper work caused her to be "horrified" by her meagre hourly rate. This WGP recognised that it was hard for organisations like the AMA to improve the financial situation for GPs. Some GPs working in disadvantaged areas and charging the rebate or bulk billing were making little money. This was also true for GPs working part-time and women GPs who performed long consultations that were "unrewarded" financially.

WGPs who receive a salary feel like second-class citizens, said a male GP:

> Women particularly do feel more comfortable in not owning businesses and being on salaries. People should not to feel like second-class citizens if they choose to be on salaries.

A rural male GP spoke of the highly paid procedural "jobs" that were attached to

hospital day-units and the absence of WGPs in these positions. He also reported that some male GPs employed WGPs to deliver services that earn disproportionately less income per hour while the male GPs were free to earn more in a shorter time:

> Because of the adverse incentives in the Medicare schedule, that often means that females earn disproportionately less income for their hours worked than do males. I think there are largely male practices which are happy to employ females on the basis that that is what the females will do, which will free up the males to earn even more in a relatively shorter time. I think that is a highly unprofessional attitude on the part of the males. I think there is one correct way to practise and that is not gender differentiated.

Another male GP said:

> I am not sure that I actually believe there are any particular disadvantages for female practitioners in their professional lives, except to observe that the current Medicare benefit schedule doesn't reward time spent with patients. It's very clear from what I've read and from my experience of working with women general practitioners that they tend to have the potential to earn significantly less than their male counterparts. They are inclined to spend longer with patients than my non-female counterparts. So what in essence that means is that for the same amount of hours put in they earn significantly less.

The same male GP elaborated further upon the financial disadvantage for WGPs in

the Practice Incentives Program and Medicare payment for longer consultations. He considered that the profession should have open and transparent discussion about these issues in order to find solutions:

> There's the element of recognising that there are work place industrial issues that currently disadvantage women in terms of the way the finance system has been structured. For example, women [GPs] will have a large number of longer consultations because the patient that wants to attend women [GPs] often has problems that take longer to sort out. There are issues around the Practice Incentive payments to practices and how that might be distributed, making assistants or non-partners or associates recognise that there is an element of that payment that should be distributed equally. I don't think we discuss that enough, advertise it enough, and there's this hush-hush about the AMA's and the College's position. I think that you've got to be open and transparent about issues that are difficult.

Some interviewees identified that the PIP is a barrier to adequately rewarding WGPs who are often not partners and work on a sessional or part-time basis. This (said a male GP) is because they are renumerated by a system based on fee for service. He thought that the RACGP had a role in advocating for WGPs with Government about this issue:

> The remuneration of GPs with the PIP and other ways which are not fee for service, while laudable and helpful is sort of not beneficial to General Practice as a reward for the provision of good service for patients. It may be a barrier to adequately

> rewarding female doctors who tend not to be partners and associates in practices and tend to work on a sessional or part-time basis and rely on fee for service as their income. These benefits of the PIP may not flow on to female GPs. I'm not sure whether the College has taken that sufficiently into account in its discussions with the government about the practice PIP payments for doctors. I often wonder about how much female GPs are being paid compared to their male counterparts for the equivalent amount of work in General Practice. I've not seen any figures comparing male and female levels of remuneration.

The participants in this research often questioned the influence that the increasing number of WGPs had on the level of income and status of General Practice. One male GP noted that:

> It's just generally recognised that in any workforce predominantly female, they enjoy less status and less remuneration.

### 7.2.11 Safety Issues for WGPs

Patients can misunderstand the close doctor-patient relationship. This was the case for a WGP who was stalked by a patient:

> I've got burnt a couple of times. I've had to take a restraining order against a female patient that stalked me as a result of becoming too closely involved. So it can work against you. But as the bloke I work for said, you just don't want to lose that

> idealism, it's so important to be involved and to become cynical and to withdraw is a real loss. He acknowledges that that is what he has done, and that he doesn't get involved as much. I think on the whole that we do get involved and there's a real difference.

One rural WGP commented on the issue of safety for WGPs who did home visits at night:

> Some of the women had been in fairly threatening situations. They found having to do house calls at night on their own when it was dark, was threatening.

Another of the male GPs recognised the difficulties that WGPs face with respect to after-hours house calls. He considered that it was necessary to find solutions to these problems:

> We were hearing criticism about the problems with after hours. It's because women doctors don't want to do after hours. They don't want to do house calls, without understanding the issues behind them and without recognising the dangers for women in doing house calls in the middle of the night. I think there are solutions to all those issues as the majority of them are real. We want to find solutions.

This GP described a model used in his practice for after-hours work on the weekends:

> In our practice the women, if they feel safe and comfortable in doing say an extra Saturday with a security person, it fits in well. There are models that do work.

Regionally based Divisional activities can be tailored tn meet the needs of the community as well as the safety of WGPs. One division developed a model project to deliver after-hours service in a secure environment:

> We have developed an after hours system working within casualty. The GPs are on salaries and formulae and hours. It's in a secure environment that suits the women practitioners who work in that area. We already know that most of them have volunteered to participate, when the vast majority don't currently do after-hours particularly in difficult environments.

### 7.2.12 Balance, Support and Equality

A male GP who had employed women GPs for over 15 years knew that WGPs had a problem balancing their various roles but he thought that they managed this very well. However, according to a rural WGP, providing a balance was the key issue:

> I mean the difficulty for women is that professional and private lives are totally inter-linked and the big issue is actually not being able to separate the two. Being able to balance private life and professional life ends up being the key thing.

Continuing the theme of balance a male GP spoke of the professional equality that

existed between the male GPs and WGPs in his practice and how the WGPs didn't expect any privileges when it came to taking a share of the work:

> Professionally we're on an equal footing. There's no difference in the hours we work and the after-hours we share and I think the women want it that way. I don't think they expect any privileges, but if they have special needs they expect consideration. I think there are times when they have time off to have a family. I don't think it's difficult at all to accommodate that. I guess it's just been recognition of professional equality and the very special contribution they have to the practice in terms of the care of patients. On the other hand, I think the men counterbalance that. Men want to see men for particular issues.

Divisions of General Practice offer support with infrastructure and payment to GPs for work done without causing disadvantage to GPs or their practice, said one WGP:

> The divisional infrastructure meant that you didn't have to do all the work yourself. You were rewarded for being involved financially as well as having the convenience of working at a time that suited. It offered a balance.

A female GP explained that Divisions were able to focus on making the life of the GP easier and supporting the active role of women:

> The Division has been very focused on making life easier. It is an organisation that has really been quite active in encouraging women to participate and was very much in a supporting role. It

> allows one to leave one's practice and do the tasks without cutting into family time so much. It's remunerated in such a way that it doesn't increase that burden that is placed on my practice. We found the Division a supportive environment. It's a funny feeling that you always defer to men. I think you get that conditioned into you at an early stage. The Division is not a perfect organisation, but a jolly lot better than a lot of others.

The issue of providing support to organisational members was described by a male GP:

> Supporting members and developing member-support is the key to the whole thing. I think the whole thing comes down to networking and being there for people. Providing what people need not just at the macro level in the medical political environment but actually at a micro level on a one to one basis.

A rural WGP thought that the RACGP had to provide something different in order to support membership:

> People just don't see the College as relevant. As soon as people realise that they don't have to continue to be College members to do QA and CME a lot of them just leave. We have to be providing something that other people aren't.

### 7.2.13 Education and Training for General Practice

Women follow men around the world to progress men's careers but men were less

likely to follow the women for the same purpose, according to one male GP, who said this problem was highlighted in a journal article:

> Jim Dickinson did a study that was published as a letter in the Medical Journal of Australia in 1994[2]. It compared the careers of women across the medical specialties and found that in fact there was a ceiling on the number of women entering and achieving specialist qualifications in spite of there being a much larger growth rate of specialties in the last 20 years. He attributed that to work practices such as you have to go overseas for two to three years in more than one country, possibly get a fellowship by examination in another country as well as to build up your experience to come back to be recognised as a sufficient standard to become a specialist in Australia.
>
> Those sorts of work practices militated against women very strongly compared to men. The wife tended to follow the husband. The husband was less likely to follow around the world tour in a career-forming phase of their wife's life. There were clear messages around workforce obstacles to career progression of women.

A male GP who was a State director of the RACGP Training program commented on the contribution of the increasing number of women GPs in the program on issues of part-time and flexible training:

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[2] Jim Dickinson's study found that the proportion of women enrolling on the Medicare specialist register had risen little (15% to 23%) over the ten years from 1984 to 1993.

> In the Training Program about 60 or 65% of the training doctors for General Practice are females. Many of these female doctors work as Registrar liaison officers and also are prominent in the National Registrar Association. I think they have quite a large input into some of the decisions made by the RACGP Training Program and endorsed by the College to support part-time training and flexibility in the training.

One rural WGP thought the College had supported women as members by providing education programs but she had doubts about QA and PD:

> Divisions offered the opportunity to participate with ongoing educatinn and professional development in ways that were different from the College. The focus was different. It was a postgraduate education focus and one is able to participate at times that suited you better.

Another WGP spoke of the importance of family support in achieving success in medical education:

> I grew up in a family where I was never ever put down because I was a woman. My Mum very much believed in women doing what they felt they wanted to do.

A rural WGP described the support that she had experienced in being trained at a UK medical school that had historically been set up by women for women:

> I went through a Medical School that originally was for women and so I had female consultants as role models. The first time that I was aware I was hitting any gender issues was when I applied for a GP Training Scheme in the UK. I was asked if I was out on a call, who was going to answer my phone since I didn't have a wife?

### 7.2.14 WGP Educators in the RACGP Training Program

A senior female employee in the RACGP Training Program felt there was no discrimination in the selection of doctors who wanted to train in the program. However, another female employee felt there was an issue of discrimination for staff GPs who worked part-time regarding the number of GP practice sessions they could do:

> With the selection interviews for new doctors wanting to come into the Program, there's certainly no selection bias. For the staff, there is an employment issue in terms of if you are working half-time or full-time. If you're working full-time you get twn practice sessions as part of your job. If you're working half-time you don't. There is a disadvantage that way in terms of part-time work. At the senior level perhaps some personalities have not understood the issues for women doctors. There has been a bit of friction from time to time.

A senior director in the Training Program claimed that WGPs training part-time training were "more available":

> Part-time training has the effect that the NRA (National Registrar Association) Chairs have been filled by women. That's because women are training part-time and therefore more available. Men tend to be more focussed on their career.

This male also said that options and flexibility were the issues considered when designing training rather than gender:

> I don't commonly think about a gender when we are designing training, or when we're organising things. I would hope that that was because gender isn't the issue. It's about ensuring that there are options and there's sufficient flexibility.

### 7.2.15 Working in Rural General Practice

For WGPs, making choices according to their individual family's needs often prohibits them from some activities that men are able to do:

> Women being traditional tend to put more emphasis on their commitments to their family. I think women make those choices relating to their family and sometimes that precludes them doing some of the things the men do. I made the personal choice never to do obstetrics and I would have quite liked to do obstetrics. I really wanted to be able to work in rural General Practice but I also wanted to have family.

The voice of women was not heard in rural areas because either WGPs were a

minority group or the women did not communicate their difficulties, explained a rural WGP:

> In rural practice women's voices have not been heard very much because womeo are in such a minority. I think for them to seek support from each other was very difficult. When I went to a rural town I was the first woman doctor there. When we had that teleconference for the RDAA it was the first time we women had ever talked to each other. "Gee" we said "We are finding this tough" and it was almost as if you said to the blokes that you were being a wimp.

A rural WGP commented that rural WGPs felt pressured to provided women's health services at the expense of having a broader clinical profile:

> In rural areas there's very few rural women doctors. There weren't other serviees like Family Planning Services or women's health nurses. The WGPs felt a lot of pressure from the other doctors and the community to do these services. Sexual assault services were something they felt pressured to provide.

Much of the work that rural WGPs were doing was time-consuming and didn't produce income equivalent to that of male GPs:

> The women were coneerned that a lot of the things that they did took a long time and didn't generate the same income as the work the blokes were doing. The blokes were earning a lot

> more money from procedural work than the women were earning for the practice. The women did a lot of counselling and were making a contribution to the practice and the community.

Living out of town was the solution for one rural WGP and her family to secure their privacy:

> Another thing was the lack of anonymity. I've had this personally a great deal having, worked and lived in a country town most of my life. You couldn't go to supermarket or playgroup or anywhere without being instantly recognisable. All the time people bowl up to me in the supermarket and want to discuss their ills. You feel you can't just go to the supermarket in a tracksuit and thongs because the whole town would then know about it. My husband and I coped with that in the end by moving out of town.
>
> The other thing that used to happen to me and to a lot of the other women was that if you weren't on for the weekend then you weren't answering your phone, they knew where you lived so they'd come to your door. Now that's probably as common for male doctors. We handled this by moving onto a property 20 minutes out of town. That meant that I had to stay in town on my nights on call but that was a compromise.

One rural WGP confirmed that rural WGPs have a different style of practice:

> Male GPs are very much into the bigger rural stuff. Women are interested in a different style of practice. I think the RDAA

tends not to see those things as being important.

When this WGP's husband was unemployed following a move from one rural location to another, she worked and he cared for the family:

> I actually supported the family and he spent a lot more time with the children and I worked in a solo practice for a number of years.

### 7.2.16 Wives Supporting Men in General Practice

Male GPs are generally supported by their wives, but WGPs have husbands with their own careers. Hence it is the WGPs who are constantly balancing the two careers, said a WGP:

> In rural practice men have often been much more supported by their wives. In the town I work in none of them had working wives. All the blokes had a wife at home putting the dinner on the table no matter what hour of the night they got home and the children would be in bed or bathed, whereas most women don't have that luxury. For most women their husbands do have some sort of a career, so that in that family the WGPs are balancing two careers.

The opportunity males have of being able to select the hours that they work is based on their having a person filling the role of a mother and housekeeper, said an urban WGP:

> The hours that males worked is based on their presumption that there was someone at home doing all the support in terms of meal provision, looking after the accounts, looking after the kids. For women to try and step into that role is incredibly difficult because they're usually doing it all at home as well.

If a rural WGP is active in organisations or the rural movement she needs a "wife". Without that other strategies have to be developed said a rural WGP:

> To be that sort of highly active working-woman and involved in medical things you need a wife. Everybody needs a wife. So people have to look at other ways of getting round these things, sharing workloads a lot more.

This same rural WGP experienced the negative attitude of a male GP who expected her to carry the same professional workload as he did:

> It more or less came down to a situation where because I was the only female doctor in the town and the only one with really young kids. From the older male members there was no feeling or real understanding of my trying to do domestic tasks. They had their wives to do that.

Urban WGPs reported a similar problem:

> I think that men have traditionally relied on their spouses to look after areas which women are not prepared to delegate or which women cannot delegate. Therefore there had to be a shift in the perceptions of professional responsibility.